

AMCNO meets with Chief Justice Moyer of the Ohio Supreme Court to Discuss Specially Trained Judge Program

Members of the AMCNO physician leadership, staff and attorneys met with Chief Justice Moyer recently to discuss the ASTAR program – The Advanced Science and Technology Adjudication Resource Center, Inc. This is a leadership consortium dedicated to enhancement of capacities of the courts via science and technology knowledge tools, including the training of resource judges.

Resource judges are meant to preside in complex cases featuring novel scientific evidence and issues. They are skilled in mediation and other procedures that may save litigants from the financial and emotional costs of lengthy trials. They provide background and procedural

information to their colleagues. They provide leadership for Bench, bar and law school education for the next generation of jurists. Resource judges are meant to promote the independence of the courts and public confidence in the courts. ASTAR
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Representatives from the AMCNO and the Co-Chairman of the AMCNO Medical Legal Liaison Committee spend a moment with the Chief Justice (l to r – Dr. Raymond Scheetz, Jr., Chief Justice Moyer, Mr. Ed Taber, Esq. and Dr. John Bastulli).

AMCNO Participates in the Ohio Health Quality Improvement Summit (OHQIS)

In November, the Ohio Health Quality Improvement Summit (OHQIS) met over three days to identify the top 10 strategies that will transform Ohio's health care system into a high quality, cost-effective, high performing system that optimizes the health of Ohioans by 2013. Participants in the Summit included physicians, healthcare executives, business leaders, employers, community advocates and others.

In early 2008, the State of Ohio was chosen as one of nine states to participate in the Commonwealth Fund/AcademyHealth State Quality Improvement Institute (SQII) — an intensive, competitively selected effort to help states plan and implement concrete action plans to improve health system performance across targeted quality indicators.

States were selected based on having the commitment, leadership, and resources necessary to build on previous success and conceptualize and implement substantive new quality improvement efforts. In Ohio, this included factors such as the Governor's focus on achieving a healthy Ohio, an interest on the part of the legislature in addressing

concerns about cost and quality, a strong desire on the part of a variety of stakeholders to address systemic issues beyond health insurance coverage, and a number of local initiatives related to improving quality.

After intensive meetings with national experts, the SQII Team decided that it made sense to pull together a diverse group of stakeholders in the state to develop a portfolio of health

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ADDRESS SERVICE REQUESTED

AMCNO meets with Chief Justice Moyer of the Ohio Supreme Court to Discuss Specially Trained Judge Program (Continued from page 1)

is a consortium of the Supreme Court of Ohio, the Court of Appeals of Maryland, the Supreme Court of Illinois, and the Supreme Court of Washington. Currently, 39 jurisdictions are ASTAR members and numerous judges in the state of Ohio have participated in the program.

The AMCNO met with Chief Justice Moyer to discuss the ASTAR program to ascertain how he plans to utilize these specially trained judges in Ohio. The AMCNO informed the Chief Justice that we continue to evaluate and review alternatives to the current tort reform system and we made it known to the Chief Justice that the availability of judges specially trained on complex medical issues is of interest to our organization. ASTAR is planning a session in 2009 of the 39 states involved in the program to

determine how to utilize these specially trained judges. Although there has been no determination made as yet by the ASTAR program on how to best utilize these judges, the AMCNO plans to follow up with Chief Justice Moyer to voice our support of their use in medical liability cases in Ohio. The AMCNO will follow up with the Chief Justice following the 2009 ASTAR meeting to garner additional information on the outcome of their discussions. ■

AMCNO Participates in the Ohio Health Quality Improvement Summit (OHQIS)

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quality improvement strategies to which a wide array of stakeholders could commit, offering the opportunity for both short- and long-term return on investment.

To this end, the Ohio SQII Team organized the Ohio Health Quality Improvement Summit (OHQIS). The calling question for the participants in this Summit was what are the top 10 strategies that will transform Ohio's health care system into a high quality, cost-effective, high performing system that optimizes the health of Ohioans by 2013?

To answer this question the OHQIS focused on developing strategies and tactics related to four areas: improving patient safety and reducing errors, promoting health through personal responsibility and disease and injury prevention, improving chronic care management and improving efficiency and decreasing cost. The participants in the OHQIS worked over the three day time frame to identify 10 strategies and supporting tactics. These strategies and tactics are being developed into a report that will be disseminated to all of the participants from the summit inclusive of the AMCNO. The AMCNO will then have the opportunity to review the report and provide our comments.

The participants in the QHQIS are to reconvene three months after the release of the report to review the strategy for implementation and to discuss the next steps in the process. Once the final report becomes available the AMCNO will provide additional information to our members. For more information about the Summit go to <http://ohqis.pbwiki.com/> ■

CORRECTION

The author of the article entitled "Enforcement Activities and Litigation Target Low Out-of-Network Reimbursement Rates" that appeared in the November/December issue of the *Northern Ohio Physician* magazine was inadvertently omitted. The author of the article was Mr. Rick Hindmand, an attorney with the Chicago office of McDonald Hopkins, LLC. AMCNO regrets the omission.

ATTENTION AMCNO MEMBERS

Is your listing accurate?



It's that time again!

Let us know of any changes to your listing for the forthcoming 2009-2010 edition of The Academy of Medicine of Cleveland & Northern Ohio's **Member Directory & Community Health Resource Guide**.

Look for a mailing to come soon that will contain your specific listing information and instructions on how to report changes to the AMCNO if needed.

Look for the new directory in late spring.

IN MEMORIAM – GEORGE H. ALLEN, JR.

The AMCNO staff sends our condolences to the family of George H. Allen, Jr., of Commemorative Publishing Company. Mr. Allen served the AMCNO for many years attaining advertising for our publications. He will be greatly missed by the AMCNO staff and the members of the AMCNO Communications and Community Relations Committee.

NORTHERN OHIO PHYSICIAN

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AMCNO Annual Resident Seminar a Huge Success

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) presented our annual resident seminar, *Preparing for the Business Aspects of Practicing Medicine* in October at the AMCNO offices. **Dr. Raymond Scheetz, Jr.**, AMCNO President and emcee for the evening welcomed residents and spouses from several area hospitals to learn about employment contracts, liability coverage, asset management, estate planning, starting a practice, and tax concerns from a lineup of expert guest speakers. The agenda's

content and speakers targeted specific issues that young physicians will face entering today's healthcare marketplace. The seminar was presented by the AMCNO and sponsored by The William E. Lower Fund. The AMCNO thanks speakers Michael Turney from Willis HRH, Rick Cooper, Esq. from McDonald Hopkins, Phil Moshier from Sagemark Consulting, John Shelley, Esq. of Squires Sanders and Dick Cause of Walthall, Drake and Wallace LLP, who were on hand to share their expertise. ■



Dick Cause, CPA, from Walthall, Drake & Wallace answers a resident's questions.



John Shelley, Esq., of Squire Sanders, speaks to residents on estate planning, tax basics and more.

Seminar Brings Valuable Updates to Practice Managers



Diana Irvin, Provider Service Representative, Medical Mutual of Ohio and associates address the audience.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to host its annual "Solving the Third Party Payor Puzzle" seminar in November where presenters from Ohio's insurance companies shared scores of useful information with attending practice managers and physicians. The AMCNO welcomed first-time presenters from Aetna and CIGNA Healthcare of Ohio who joined the seminar as a direct result of feedback from prior attendees. Other returning presenter organizations included Medical Mutual of Ohio, Palmetto GBA, the Ohio Department of Job and Family

Services (ODJFS), UnitedHealth Care, and Anthem BC/BS.

A common-thread key initiative shared by presenters was the ability to offer user-friendly, highly robust Web portals to better meet service needs and aid in things such as claim submissions and status, precertification, electronic remittance and more. Other valuable tools and resources include free e-courses, download of forms, and fee schedules. These things minimize provider administrative costs and offer solid cost-saving benefits, which promoted the vital importance of electronic viability to practitioners.

Palmetto GBA, summarized the new Medicare initiatives, discussed top error categories and provided status of contracts and reform for Ohio. The Ohio Department of Job and Family Services (ODJFS) provided an overview of Medicaid Managed Care

and shared 2008 provider agreement and rule changes. Dr. Giesele R. Greene from UnitedHealthCare spoke about the hospital observation versus admission status and detailed what constitutes outpatient status. Dr. Greene also pointed out that observation status helps doctors' efficiency scores. Throughout the day presenters fielded questions from the audience with attendees even lining up offline to get answers to their questions/concerns. ■



Attendees at the annual AMCNO seminar garnered important information from the presenters.

Annual “Vote and Vaccinate” Program Receives Media Coverage

The Academy of Medicine of Cleveland & Northern Ohio hosted its ninth annual “Vote & Vaccinate” program on Election Day, Nov. 4, 2008 in neighborhoods where influenza and pneumonia vaccination rates among senior citizens are reportedly low. The successful program provides the public with an opportunity to receive flu and/or pneumonia shots at area polling sites. It is a parallel program to voting and not connected in any way with the Board of Elections.

The goal is to offer seniors these vaccinations conveniently at locations where they vote on Election Day. Proud sponsors of the annual program include the AMCNO, the Cleveland Dept. of Health, the Cuyahoga County Board of Health and Parma Community General Hospital. Our sincere appreciation to all the locations’ staff and allied health professionals who helped make this worthwhile event possible, including those at Royal Redeemer Lutheran Church, Ridgewood United Methodist Church,

Parma Heights Baptist Church, Pilgrim Congregational United Church of Christ, Normandy High School, Open Door Baptist Church and the Parma South Presbyterian Church.



Cuyahoga County Board of Health nurse, Lori Kowel administers vaccine at Parma South Presbyterian Church.



Dr. Raymond Scheetz, Jr., president of the AMCNO is interviewed on the Vote and Vaccinate program by reporters from Cox Cable.

This year’s program received media coverage from the WKYC news station and Web site as well as a live interview with the AMCNO president, **Dr. Raymond Scheetz, Jr.**, by Cox Cable at a Parma location. The AMCNO plans to repeat this worthwhile event in 2009. Any group or hospital that may be interested in working with the AMCNO as a co-sponsor on this event or would like to host a site for the Vote and Vaccinate program should contact the AMCNO offices at (216) 520-1000. ■



Dr. Gwendolyn Lynch speaks to the Tri-C Encore College group about “Keeping Yourself Stroke Free.”



Dr. Rick Grimm fields questions from 6th – 8th grade students of the Junior Medical Club.

AMCNO Speakers Bureau Responds to Community

AMCNO members **Dr. Rick Grimm, DO** and **Dr. Gwendolyn Lynch, MD**, both of the Cleveland Clinic, assisted with Speakers Bureau engagements this past fall. Dr. Grimm spoke at the Junior Medical Club in Hudson, Ohio. This one-of-a-kind club opened its doors this fall to more than 14 area boys and girls in 6th–8th grades who are high-achievers and gifted learners and have an intense interest in future careers in medicine. Students eagerly raised their hands to ask Dr. Grimm general questions about his profession and listened intently as he enthusiastically shared his insights, i.e., how long did he have to go to school; what does he do as a doctor of cardiovascular disease; what is a typical day like, and more. Dr. Grimm then moved into talking about the heart and new cutting-edge treatments for heart disease. Dr. Lynch shared information about “Keeping Yourself Stroke Free” with more than 100 members of Tri-C’s Encore College, which offers programs of interest to senior citizens. More specifically, Dr. Lynch talked about stroke prevention, and how to recognize and address the symptoms of a stroke. Detailed slides supported Dr. Lynch in a successful delivery of this topic.

The AMCNO wishes to thank Dr. Grimm and Dr. Lynch for committing their time and providing valuable information to these area groups. The AMCNO Speakers Bureau receives ongoing requests for speakers from organizations in our area. Anyone interested in participating in this worthwhile program should call Debbie Blonski at (216) 520-1000 ext. 102. ■

Understanding and Surviving the Current Economic Market

By Philip Moshier, CFP, CRPC
In conjunction with Sagemark Consulting, a division of Lincoln Financial Advisors, a registered investment advisor.

Financial practices are not unlike health practices. Whereas a physician might determine the best preventive practices to protect a patient's health, financial planners design portfolios in anticipation of volatility, not in reaction to it, and are constantly studying market conditions and their effects on our clients' money. Though the recent economic conditions indicate a downward turn, the stock market has always been a market of extremes. The range of returns from common stocks in any given year is wide, and there's about a 33% chance that stocks could lose money, as measured by the broad market averages. Successful market timing during a decline is extremely difficult because it requires two near-perfect actions — getting out at the right time and getting back in at the right time. But by preparing for the worst and hoping for the best, your investments and savings will be best equipped to endure any short-term losses that result from industry changes.

Declines in the Dow (1900-2007)

	NUMBER OF DECLINES SINCE 1900	AVERAGE LENGTH (DAYS)	FREQUENCY
"Routine" Declines (5% + Loss)	360	39	3.3 per year
"Moderate" Corrections (10% + Loss)	117	106	1.1 per year
"Severe" Corrections (15% + Loss)	58	211	1 every 2 years
"Bear" Markets (20% + Loss)	31	367	1 every 3 years

Source – Oppenheimer Funds – Ned Davis Research – 12/31/07

It is apparent that in a recession, most industries will experience rising costs, consolidation, and reduced spending. In medicine, these changes can affect healthcare coverage, funding for research, and medical costs. While medical care will be a necessity despite the welfare of the economy, no one can predict consistently when market declines might happen and how they might affect your practice; the only sure thing is that they will happen. The best thing any investor can do is to stay as informed and proactive as possible, and take a long-term view. When measured over time, the stock market's prospects improve and the chances of volatility decrease. History shows that the longer you hold on to an investment, the higher the chances are that you will come out ahead. Living with market decline isn't easy, but if you keep certain hints in mind, you'll be a better informed investor.

Start early and invest regularly

By starting to invest early, you can grow a balance greater than if you had started saving later in life. When comparing the end

balances of a 25-year-old who invests \$4,000 per year at the same annual rate of 8% as a 45-year-old who invests the same amount, the 25-year-old could accumulate nearly six times more money. As with health, if you are smart with your money from a young age, it will pay off in the long run.

Create a diversified portfolio with foreign exposure

Most investment professionals today believe in creating a diversified portfolio that includes exposure to global stock markets. Diversity is beneficial because half of the world's largest public companies are located outside the U.S. and historically, fast growing foreign markets have racked up impressive gains. That being said, having a portfolio that contains the right mix of U.S. and foreign investments may actually reduce risk by offering opportunity to benefit from strong performance in one market while offsetting downturns in another. If there is any investment you have that you do not understand or have questions about, talk to your advisor about it. It is important to

understand your total portfolio and all its individual parts.

In times of uncertainty, take a long-term view and stay the course

A study by Ned Davis Research show that Standard & Poor's 500 Composite Index has tended to bounce back quickly after bottoming out during the past 10 recessions. While no one can predict a market bottom, the investors who maintained a long-term perspective and held onto their investments stood to benefit while those who sold to avoid the pain of a recession and reinvested later could have missed most of the subsequent recovery. In addition, although they feel like turbulent times, recessions can represent a buying opportunity for investors who stick to a program of investing regularly. There's no guarantee the market will turn around soon after a recession, and past results are not predictive of results in future periods. However, the S&P 500 generated positive results in nearly every three, six, nine, and 12 month period following its low point during the last 10 recessions.

To help stick to these key points, there's no better time to have a solid financial plan. This will allow you to monitor and change your risk tolerance as your personal situation changes. In addition, a financial plan is like a good prescription or a personalized roadmap. While the path to retirement may be full of bumps or obstacles, a financial plan can help you pursue a path from point A to point B. To protect your savings, start investing early, maintain a diversified portfolio, and take a long-term perspective. Market volatility affects everyone, and while nothing can assure guarantees, working with a financial planner to put a strong financial plan in place greatly increases the likelihood that you will be able to weather any storm you encounter and meet your goals in retirement.

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AMCNO Legislative Report

By: *Michael Wise, AMCNO Lobbyist*

2008 Elections

The 2008 elections made history on multiple fronts. The Obama win, political dollars spent, the switch in control of the Ohio House, and another failure of casino gaming were the big stories.

With President-elect Barack Obama (D) defeating John McCain (R) by a 51-47 percentage margin in Ohio, Democrats here were also picking up two Congressional seats and winning control of the Ohio House — by a 53-46 margin. Republicans continued to hold a firm majority in the Ohio Senate, 21-12.

In Congress, the seat of retiring Congressman Ralph Regula (Canton area) was not retained by the Republicans. Democrat State Senator Steve Bocchieri won that seat while in the 1st Congressional District, Republican Steve Chabot was also defeated. Democrat State Senator Steve Driehaus was the victor in that race. Changes also occurred in the 5th Congressional District due to the retirement of Republican Deborah Pryce. That victor was Franklin County democrat Commissioner Mary Jo Kilroy. Ohio's two U.S. Senators were not up for re-election. Republican George Voinovich will face reelection in 2010.

Ohio Supreme Court: Both Justice Stratton and Justice O'Connor won reelection to the Ohio Supreme Court. This was done with the help of the AMCNO and support from the physician community. Justice Stratton claimed a big 63 percent to 37 percent victory over Cuyahoga County Common Pleas Judge Peter Sikora, while Justice O'Connor defeated another Cuyahoga County Common Pleas Judge, Joseph Russo 67 percent to 33 percent. 2010 will be a big year for the Court as three seats will be up including the Chief Justice.

Common Pleas and Appellate Judges: The Academy's PAC supported three local races in Cuyahoga County and all those judges were victorious. Those judges included Democrat Larry Jones in the 8th District Appellate Court and Richard McMonagle and Deena Calabrese for the Court of Common Pleas. However, the PAC supported candidate in Lake County was

Randi LeHoty and she was unsuccessful in her race for Lake County Common Pleas.

Ohio Attorney General: In the Ohio Attorney General race, Democrat Richard Cordray defeated Republican Michael Crites. This office is important to physicians because of its oversight of non profit entities and because of its potential role in the physician ranking issues. Cordray will now stand for reelection in 2010 against a yet to be determined Republican.

Northern Ohio Candidates

Ohio House race – District 18 (Cuyahoga): Incumbent: Rep. Jennifer Brady (D). Brady was beaten by the Republican candidate, Nan Baker, a Westlake city councilwoman and small-business owner. Baker beat out Brady 51 percent to 49 percent.

Ohio House race – District 20 (Cuyahoga): Incumbent: Rep. Thomas Patton (R), ran for the Senate. Back in July, State Senator Bob Spada made the decision not to run for this House seat which forced the Republicans to locate a new candidate, Colleen Grady. Ms. Grady lost to Democrat Matt Patten by a 51 percent to 49 percent margin.

Ohio House race – District 63 (Summit): Incumbent: Rep. Richard Nero (R). Nero was appointed to this seat in June after Rep. John Widowfield resigned from the Ohio House. Democrat Mike Moran, a Hudson city councilman beat Nero, claiming 56 percent of the vote to Nero's 44 percent.

Ohio House race – District 92 (Lake): Incumbent: Carol Ann Schindel a Republican, faced Democrat Mark Schneider, a Cuyahoga County assistant prosecutor. Schneider won over Schindel by a 54 percent to 46 percent margin.

Ohio Senate race – District 24 (Cuyahoga): Rep. Thomas Patton, won in Senate District 24, a district which includes the outer edges of Cuyahoga County to the west, south and east. Democrats supported Gary Kucinich, the brother of Congressman Dennis Kucinich (D-Cleveland), but he lost to Patton by a 31 percent to 69 percent margin.

In the State House, the new Speaker will be Armond Budish from Beachwood. Budish, who is a lawyer, has close ties to Lt. Governor Lee Fisher. Rep. Matt Dolan, who took the reigns of the GOP Caucus Campaign Committee this year, has decided not to run for minority leader. House Republicans have now given up a net 14 seats in the past two years. The election pointed to another political axiom, that political leadership can be very fleeting. Former Speaker Jon Husted, who was term limited, did win his race for an Ohio Senate seat.

In a post-election comment, Ohio Senate President Bill Harris forcefully predicted there would be no tax increases next year, thereby setting the stage for a potential fight with Governor Strickland and House Democrats when the next biennium budget is considered in 2009.

State Budget: The state budget is in its worst shape since the Great Depression. In December the Governor depicted an apocalyptic future budget scenario replete with unprecedented government program desolation resulting from more than \$7 billion in cuts. The administration released a compilation of what could be the greatest hits ever absorbed by state departments in terms of their available funding from one biennium to the next. A sampling of the cuts that would ensue under the most drastic circumstances:

K-12 education – cut by \$2 billion in FY 2010, with per-pupil funding shaved by \$840 in FY 2010 and \$870 in FY 2011. The funding levels would equate to those in 2001.

Higher education – cut by \$707 million next year, reducing full-time equivalent student payments to universities by \$1,987.

Alcohol and drug addiction treatment – eliminated for 10,000 citizens as federal funding would also suffer when the state fails to meet its matching requirement.

All agencies were asked to identify what a 25% reduction to their budgets might look like to provide a very clear picture and very tangible understanding of the potential impact on the state if there is no federal assistance. Clearly, this budget condition could make it very difficult to expand health care coverage in the state.

Physician Ranking

While this legislation has not passed the General Assembly, AMCNO has been working with Senator Bob Spada and Representative Tom Patton on this issue for most of 2008 and both HB 622 and SB 355 have been introduced. The purpose of this legislation is to provide the patient with accurate information when selecting a physician. This legislation would prevent the health insurance company from ranking a physician solely based on one specific criteria to persuade a consumer to choose one physician over another. The designations would be made based on cost efficiency, quality of care or clinical experience. The legislation also allows physicians the right to review and appeal their ratings prior to the ratings being released to the public. Senator Spada is term limited but was eager to assist AMCNO with this initiative. Representative Tom Patton will be succeeding Senator Spada and will be leading this effort in 2009.

Executive Branch Issues

As a follow-up to the issues with Ohio Tobacco Prevention Foundation (OTPF), the General Assembly had passed and the Governor signed legislation to abolish the Foundation. The legislation effectively eliminated funding tobacco prevention and cessation programs. The week of December 8, 2008, SB346 (which would allow smoking in all businesses that are not publicly traded and private clubs — regardless of whether there are children, employees, or the public is invited) was considered in the Senate Health, Human Service, and Aging Committee. So far, only Senator Schuler, the sponsor, has testified and it appears that this Bill will not move any further this General Assembly. All in all, after great success in 2006, this year has been more difficult for smoking cessation efforts.

This same conclusion was reached by the Washington, D.C.-based Campaign for Tobacco-Free Kids. A new report entitled "A Decade of Broken Promises: The 1998 State Tobacco Settlement Ten Years Later," was released by the Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society Cancer Action Network, American Lung Association and Robert Wood Johnson Foundation.

The 10th anniversary of the settlement comes as recent surveys have shown that

the nation has made significant progress in reducing smoking in the past decade, but smoking declines have slowed in recent years. From 1997 to 2007, smoking rates declined by 45 percent among high school students and by 20 percent among adults. But 20 percent of high school students and 19.8 percent of adults still smoke, and tobacco use remains the nation's leading cause of preventable death, killing more than 400,000 people and costing nearly \$100 billion in health care expenditures each year.

Key findings of the report include:

Over the past 10 years, the states have received \$203.5 billion in tobacco-generated revenue — \$79.2 billion from the tobacco settlement and \$124.3 billion from tobacco taxes. But they have spent only 3.2 percent of their tobacco money — \$6.5 billion — on tobacco prevention and cessation programs.

This year, no state is funding tobacco prevention programs at the levels recommended by the U.S. Centers for Disease Control and Prevention. Only nine states are funding tobacco prevention at even half the CDC-recommended amount, and 27 states are providing less than a quarter of the recommended funding.

According to the report and the FY2009 Rankings of Funding for State Tobacco Prevention Programs, Ohio ranked 45th in the amount of money utilized from the state tobacco settlement funds for tobacco prevention for kids. The report showed that Ohio is spending less than 5 percent of the level recommended by the Centers for Disease Control and Prevention on tobacco prevention programs. Ohio currently spends \$7.1 million a year on such programs, while the CDC recommends \$145 million a year, according to the report. According to the report the tobacco industry spends \$724 million a year on marketing in Ohio.

The report noted that this year alone, the states will collect \$24.6 billion in revenue from the tobacco settlement and tobacco taxes, but will spend less than three percent of it on tobacco prevention programs. It would take just 15 percent of this tobacco revenue to fund tobacco prevention programs in every state at CDC-recommended levels.

This report illustrates why the AMCNO and the Investing in Tobacco Free Youth Coalition in Ohio are advocating for legislation that would increase the tax on other tobacco products (OTP) to provide for additional funding for tobacco cessation programs in Ohio. We plan to continue our efforts on this initiative with the Governor and with new General Assembly beginning in 2009.

To view the full report as well as the rankings by states to go:

<http://www.tobaccofreekids.org/reports/settlements/2009/fullreport.pdf>

<http://www.tobaccofreekids.org/reports/settlements/2009/staterankings.pdf>

We are now through with this two-year legislative cycle. 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. ■



On Election Day, the AMCNO had doctors at polling sites to provide information to the voters on the judicial races of importance to physicians — in particular the Ohio Supreme Court judicial race. Pictured above at a polling site in Shaker Heights are Dr. John Bastulli and Dr. Paul Janicki — both past presidents of the AMCNO.

The Affidavit of Merit: Update

By: *Christina Marshall, Esq.*
Sutter, O'Connell and Farchione law firm

In the last issue we presented to our readers the *Fletcher* case, which was then pending before the Supreme Court of Ohio for a determination as to the future of the "Affidavit of Merit" filing requirement. By way of background, Ohio Rule of Civil Procedure 10(D)(2) requires a plaintiff alleging a medical, dental, optometric or chiropractic malpractice claim attach an affidavit of merit to their Complaint relative to each named defendant. The affidavit of merit is a statement by an expert witness that they have reviewed the medical records of the case, are familiar with the applicable standard of care, and can provide an opinion necessary for the plaintiff to establish liability. The intent of the Rule was to discourage the filing of frivolous lawsuits in the State of Ohio.

In the *Fletcher* case, the Plaintiff failed to file the requisite affidavits of merit to support her medical malpractice claims against the named hospital and physician. The trial court granted the Defendant-hospital's Motion to Dismiss, and the Plaintiff appealed the Judge's decision to the Eighth District Court of Appeals in Cuyahoga County. The Court of Appeals reversed and reinstated the lawsuit, holding that the trial judge should not have immediately dismissed the case. Rather, the Defendants were required to file a motion requesting "a more definite statement" as to Plaintiff's allegations, before requesting an outright dismissal.

The clear implication of this decision was that a plaintiff who had failed to file the necessary affidavit of merit suffered no penalty. By forcing defendants to request additional information about plaintiff's allegations before ultimately moving for a dismissal, medical care providers in Ohio would have been forced to expend additional time, effort and resources into the litigation by engaging in time-consuming and costly motion practice. It would be the defendant's burden to bring the deficiency of the Complaint to the court's attention.

The Eighth District decision appeared contrary to the Rule's intent to discourage frivolous lawsuits and lessen the burden on trial court dockets. Both the hospital and physician appealed the decision to the Supreme Court of Ohio, which granted jurisdiction as the appeal presented an issue of public or great general interest. After extensive briefing the case was argued on September 30, 2008 to the Supreme Court Justices, who announced their decision on October 23, 2008.

In a straightforward opinion authored by Justice Maureen O'Connor, the Supreme Court of Ohio unanimously decided that Civil Rule 10(D)(2) imposes a heightened pleading burden on plaintiffs alleging medical malpractice claims. The Court also agreed that policy considerations warrant limiting the number of medical claims. The affidavit requirement goes directly to the sufficiency of the Complaint and a plaintiff can no longer rely on unsupported conclusions that the defendants committed malpractice. In the absence of an affidavit of merit, a defendant may move the trial court for immediate dismissal of the Complaint, for failure to state a claim upon which relief may be granted.

The decision was a victory for medical care providers and insurers as it acknowledged the need to decrease the number of medical claims on Ohio's court dockets and fortified the Civil Rule requirement of filing an affidavit of merit. However, the effectiveness of the Rule in real-world application and enforcement remains to be seen. The Rule currently allows courts to give plaintiffs additional time to obtain an affidavit of merit if it one was not readily available at the time of filing their Complaint. Granting such an extension of time must be for "good cause," and the court may consider such things as the type and scope of discovery necessary for plaintiff to obtain the affidavit, whether the information necessary to obtain an affidavit is in the possession or control of a defendant or third-party, and what efforts have been taken to obtain that information. Therefore, failure to attach an affidavit of merit to a Complaint does not automatically result in a dismissal. Plaintiffs may still name, in "shotgun" fashion, numerous medical providers in a single malpractice Complaint and prolong litigation to conduct discovery. But the recent decision in *Fletcher* provides assurance that the Supreme Court and General Assembly are committed to improving the court system and diminish the number of frivolous medical malpractice claims. ■

AMCNO Medical Legal Liaison Committee Advises Physicians "To Be Your Own Advocate"

One of the key committees of the AMCNO is the Medical Legal Liaison Committee. As members of the committee evaluated the ramifications of the opinion in the *Fletcher* case they also discussed how physicians could be proactive when faced with medical liability cases. Listed here are two key points that physicians should consider in the future when faced with litigation matters.

1. Although litigation can never be entirely avoided, there are a few proactive measures medical providers can take to decrease the chances of becoming named in a frivolous suit or obtaining an early dismissal from a frivolous case. If you have been notified of a claim, but no lawsuit has been filed, it may be beneficial to retain personal counsel and consult with them concerning the facts of the case and why you believe the claim does not involve the care or treatment you rendered, if any. Your attorney may also be able to provide you with an opinion letter regarding the merits, or lack thereof, of the claim.
2. If you have already been named in a complaint in which the plaintiff took a "shotgun" approach to identifying defendants, contact your assigned counsel and work with them early to seek a dismissal from the matter for noninvolvement. Be sure to obtain a copy of the dismissal entry, or have your assigned counsel prepare correspondence confirming your dismissal from the case, so that it is available in the future when renewing an application for insurance or completing a new application to change insurance.

CMS Updates the Stark Physician Self Referral Rule

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

The Centers for Medicare and Medicaid Services (CMS) revised the Stark II physician self-referral rule twice this year — once with the Inpatient Hospital Final Rule and more recently with the Medicare Physician Fee Schedule (PFS) Rule. While some joint ventures and leasing arrangements will no longer be allowed, CMS has also provided some leeway with alternative methods of compliance when providers need a reprieve from the harsh demands of the rule.

The Stark law prohibits physician referrals to an entity for certain “designated health services” covered by Medicare if a financial relationship exists between the referring physician (or an immediate family member) and the entity, unless the arrangement meets an exception. An entity furnishing services pursuant to a prohibited referral may not bill Medicare for the services and, along with the physician, may be subject to civil monetary penalties and exclusion. Many of the changes under way will affect indirect relationships with hospitals, either through affiliated entities, joint ventures or physician organizations.

October 2008 Changes to Compensation Relationships

Under the “stand-in-the-shoes” requirement adopted last year, CMS presumes a financial relationship with each of the referring physicians in a physician organization when an entity that bills Medicare enters a financial relationship with the physician organization itself. CMS delayed application of the rule to academic medical centers and certain 501(c)(3) integrated healthcare system arrangements due to industry concerns that it would unnecessarily stifle the use of support payments from hospitals to affiliated physician practices.

Effective October 1, 2008, CMS narrowed the stand-in-the-shoes rule to those organizations with physician owners having profit distributions and investment returns. CMS specifically excluded physicians with only a titular interest (e.g., holding shares in trust for the benefit of a hospital) and physicians covered by the current academic medical center exception.

If a physician is eligible for profits and distributions as an owner in a physician organization having a financial relationship with an entity that bills Medicare for designated health services, the Stark law will now regulate that relationship directly and

require a specific exception. As a result, most of these financial relationships will require a written agreement of at least one year that is commercially reasonable, signed by both parties in advance, and including payment terms consistent with fair market value for rent or any items and services provided.

In a brief respite, CMS created a grace period for arrangements that otherwise meet an exception but are missing the signatures required by the applicable exception. If the written agreement is missing the necessary signature, it can be obtained within 90 days if inadvertent (and within 30 days if non-inadvertent) so long as the other conditions are met and this alternative method has not been used within a three-year period.

Hospitals are also preparing for CMS to implement new Disclosure of Financial Relationship Reports (DFFR), requiring the hospital to furnish information to CMS within 60 days on all ownership and compensation arrangements with physicians. As a result of these changes, physicians and physician organizations can expect increased emphasis on both the disclosure of these relationships as well as the documentation required to pass muster and more rigid formalities when contracting with hospitals and health systems.

October 2009 Changes to Joint Ventures and Leases

CMS finalized to expand the types of entities regulated by the Stark law beyond simply those entities that bill Medicare directly and to tighten up the compensation methodologies that can be used in leases and certain compensation arrangements. Anticipating that the industry would need time to implement these structural changes, CMS allowed a grace period for transitioning to the new rule and it will not take effect until next October.

As expected, CMS finalized restrictions on “per click” and percentage-based leases governed by the Stark rule based on the concern that physicians will be rewarded for referrals (i.e., the rental charges reflect services provided to patients referred by the lessor physician to the hospital lessee based on a per-use or per-service fee). Rental payments for office space and equipment cannot be based on a percent of revenue or the number of procedures performed even if the payment is considered to be at fair market value. Office and equipment leases that are not based on a set, fixed-in-advance rental payment should be reviewed before the October 1, 2009 deadline and may need to be restructured if the leasing arrangement violates the new conditions.

In an about face, CMS reversed its previous position allowing “under arrangements” alignment models with hospitals. An “under arrangements” alignment model is a structure through which referring physicians provide goods and services to a hospital directly, or through a joint venture with the hospital, and the hospital then bills Medicare “under arrangements” and pays the joint venture for the services provided (e.g., imaging, outpatient services, cardiac cath labs). CMS considers turnkey arrangements whereby the joint venture performs essentially all of the services relating to the hospital service a business model fraught with problems and will begin to regulate the joint venture entity under Stark effective October 1, 2009. Outside the wholesale turnkey approach, hospitals can continue to obtain personnel and services from physician groups under the personal services exception and can lease space and equipment by avoiding per-click and percentage based rentals as set forth above, but the fine lines between the two business models must be analyzed on a case-by-case basis.

On the Horizon: Gainsharing 2.0

In the PFS Rule published in November, CMS re-opened for comment its proposal for certain arrangements allowing referring physicians to participate in hospital compensation pools for quality and cost savings initiatives. The AMA and others have previously commented that these so called “gainsharing” arrangements encourage collaboration, create hospital efficiencies, and fund quality initiatives if appropriately structured. Gainsharing is allowed currently if it meets the existing

(Continued on page 10)

CMS Updates the Stark Physician Self Referral Rule (Continued from page 9)

Stark exceptions, although these are considered a bit cumbersome.

Some observers are disappointed that CMS did not finalize a more flexible exception now. Instead, CMS solicited additional comments on 55 specific issues it is studying dealing with hospital shared savings and incentive payment programs for quality initiatives. CMS seems committed to working toward a solution that allows physicians to benefit from working more closely with hospitals while addressing concerns that sham measures and rewards for referrals would be allowed. Given that the U.S. Health and Human Services (HHS) Office of Inspector General (OIG) has now issued 12 advisory opinions approving gainsharing agreements, additional flexibility on the part of CMS for hospital and physician alignment on cost-savings and quality improvement measures seems warranted. With value-based purchasing and other Medicare reforms on the horizon, physicians and hospitals should delineate what CMS and the OIG consider to be proper in structuring both short- and long-term alignment strategies.

Amy S. Leopard is a partner at Walter & Haverfield LLP who represents health care clients on business and transactional issues, regulatory compliance and government investigations. She may be reached at (216) 928-2889 or aleopard@walterhav.com. ■

Healthlines 2008

The Academy's *Healthlines* radio program has provided medical information and the insight of our member physicians to listeners for more than 40 years. With hosts **Anthony Bacevice, MD** and **Ronald A. Savrin, MD**, *Healthlines* is broadcast on WCLV 104.9FM at 5:45 p.m. every other Monday, Wednesday and Friday and is brought to the community by the Academy of Medicine Education Foundation (AMEF). Listed below are the featured physicians and their respective topics that aired in 2008. To listen to an MP3 recording of a taped subject that interests you, click on the *Healthlines* link at www.amcnoma.org.

Thank you to the following interviewees who appeared on *Healthlines* in 2008:

Shashidhar Kusuma, MD	Mira Milas, MD
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Tracy Hull, MD	Mike Anderson, MD
Henry Bloom, MD	Robert Tomsak, MD
Louis Keppler, MD	Edmund Sabanegh, MD
Norman Clemens, MD	Susan Lasch, MD

Any physician member of the AMCNO may appear on the *Healthlines* radio program. If you are an AMCNO member and are interested in appearing on the program for 2009, please contact the AMCNO offices at (216) 520-1000 for more information.

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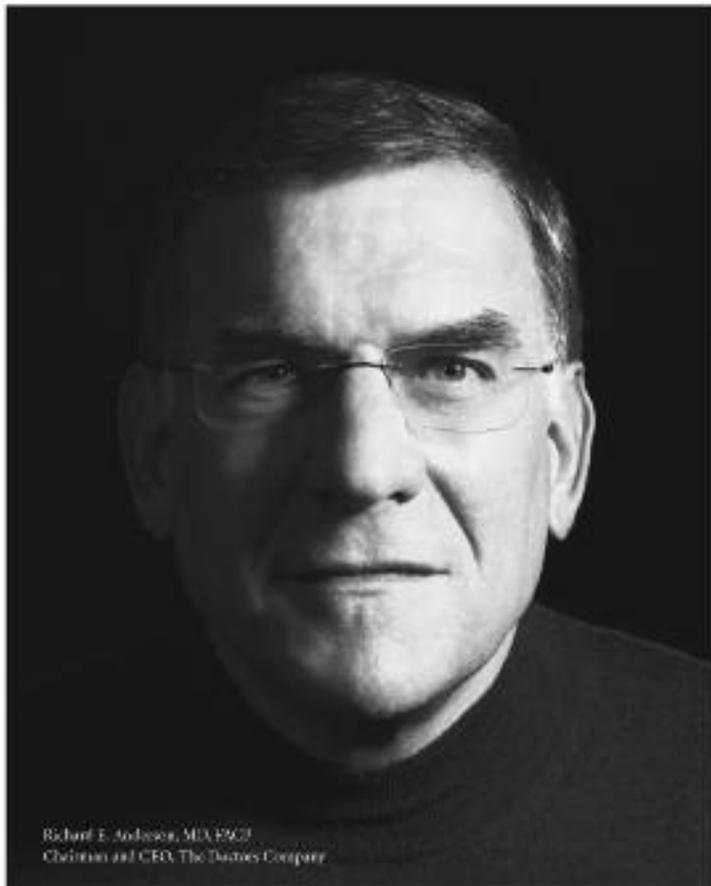
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AMCNO responds to Centers for Medicare and Medicaid Services (CMS) special study to consider changes to geographic practice cost indices (GPCIs)

On behalf of our membership, the AMCNO has sent our comments to CMS regarding a recent study conducted for CMS by Acumen LLC — “Review of Alternative GPCI Payment Locality Structures.” CMS contracted with Acumen, LLC to conduct a preliminary study of several options for revising the payment localities. The study was commissioned by CMS because of the myriad comments received from across the United States regarding the GPCI configuration. The AMCNO was one of the organizations to express concern to CMS regarding the GPCIs.

The Medicare physician fee schedule adjusts physician fees for area differences in physicians’ costs of operating a private medical practice. Three separate indices, known as geographic practice cost indices (GPCI) raise or lower Medicare fees in an area, depending on whether the area’s physician practice costs are above or below the national average. These GPCIs adjust physician fees for variations in physicians’ costs of providing care in different geographic areas. The three GPCIs correspond to the three components of a Medicare fee: physician work, practice expense, and malpractice expense.

At this time, CMS uses 89 physician payment localities among which fees are adjusted. CMS recognizes that changing demographics and local economic conditions may lead to increased variations in practice costs in certain payment locality boundaries. Currently, the state of Ohio is designated as a statewide locality. Based upon the AMCNO review of studies on the GPCI calculations, a statewide locality in Ohio clearly does not accurately account for the variations in practice costs in certain payment localities — particularly in Northern Ohio.

The Acumen study clearly demonstrates that there is a very real need to change the current GPCI locality configuration to reflect the area differences in the state of Ohio. In fact, the Acumen study showed that every alternative outlined for the state of Ohio in the Acumen study would benefit physicians practicing in Northern Ohio based upon the data analyzed in the study.

Upon review of the Acumen study, the AMCNO board of directors opted to support Option 1 in the study – the CMS CBSA option. This option as outlined in the study follows the approach CMS uses to develop geographic payment adjustments for other major Medicare providers. It is a preferable option because it utilizes Metropolitan Statistical Areas (MSAs)

and Metropolitan Divisions (MDs) to form localities. This option, as noted in the Acumen study, also “allows for more stability in updates

over time and data availability because of the use of MSAs.” The AMCNO believes that this option also assures uniformity and provides for a common base for updates across all types of providers in Ohio. The AMCNO has urged CMS to carefully evaluate the Acumen study and consider including one of the options (preferably Option 1) in the 2009 physician update.

As the regional organization representing physicians in Northern Ohio the AMCNO continues to advocate for a change in the payment localities utilized in Ohio. The AMCNO will continue to follow-up with CMS in the future to assure that our comments have been noted. A copy of our letter to CMS is printed here for review. Any questions regarding this issue may be forwarded to E. Biddlestone at the AMCNO at (216) 520-1000, ext. 100. ■



November 1, 2008

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd., Baltimore, MD 21244-1850

Re: Availability of an Interim Study of Alternative Payment Localities under the Medicare Physician Fee Schedule – Acumen LLC Study entitled “Review of Alternative GPCI Payment Locality Structures”

To Whom It May Concern:

As President of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), an organization representing more than 5,000 physicians in Northeastern Ohio I am writing on behalf of the organization and the physicians we represent to comment on the study entitled “Review of Alternative GPCI Payment Locality Structures” conducted by Acumen, LLC which was requested by the Centers for Medicare and Medicaid Services (CMS).

The AMCNO has myriad concerns regarding the usage of geographic practice cost indices (GPCIs) and provided our detailed comments to CMS last year in response to CY 2008 PFS proposed rule and final rule with comment period (72 FR 38139 and 72 FR 66245, respectively) and again this year in response to Proposed Rule CMS-1403-P on the usage of the GPCIs as well as our suggestions regarding options that we believe would be better suited for physicians in Northern Ohio (please see attached letters). The AMCNO strongly believes that Medicare’s geographic payment adjustment formula does not accurately reflect practice costs in Northern Ohio. Currently, the state of Ohio is designated as a statewide locality. This is problematic for our physician members practicing in Northern Ohio because CMS has not revised the geographic boundaries of the physician payment localities since the 1997 revision. Also, since that year, CMS has indicated that the only mechanism the agency has set forth to modify the payment localities is for the state medical associations to petition for change by demonstrating that the change has the overwhelming support of the physician community. This mechanism for change in the payment localities seems biased since the state medical association does not represent all of the physicians in the state of Ohio. In addition, CMS has not required medical associations in the states that are now consolidated to continue to demonstrate that there is “overwhelming” support from the physician community for a statewide payment locality.

The 2008 Proposed Rule CMS-1403-P outlined several options to address the GPCI calculation issue. In response to the options outlined in the CMS 1403-P, the AMCNO indicated that we would favor either Option 2 or Option 3 as outlined in the rule. Both of these options appear to have been suggested by MedPAC and they mirror the options outlined by the Government Accounting Office (GAO) report released last year which addressed the issue of the usage of GPCIs. Option 2 would remove higher cost counties from their existing locality structure and each would be placed in their own locality, while Option 3 removes higher cost metropolitan service areas (MSAs) from the “rest of the State” locality. We believe that either of these options as outlined in the 2008 Proposed Rule would result in a fairer methodology for the physicians located in Northern Ohio.

The AMCNO noted that options 2 and 3 in the Acumen LLC study were similar to the options outlined by both MedPAC and the GAO, options that would benefit physicians in Northern Ohio. However, the Acumen study offers yet another option that had not been addressed in previous CMS rules which the AMCNO physician leadership found of interest. We noted that Option 1 – the CMS CBSA option – is based on geographic areas defined by the Office of Management and Budget, and uses Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) to form localities in each state. In this option counties not included in MSAs are combined into non-MSA rest of the state areas. The AMCNO believes that this option is viable due to the fact that it is based upon the localities used to pay other Medicare providers, such as hospitals, skilled nursing facilities and ambulatory surgery centers, which allow for a more focused recognition of geographic cost differences. If implemented, this option would create additional localities in Ohio and would benefit the physicians in our area of the state, however, other metropolitan areas in the state would appear to benefit as well with this option.

It would appear that any of the options noted in the Acumen study would benefit the physicians practicing in Northern Ohio based upon the graphs and information provided, however, the AMCNO leadership did agree that since Option 1 in the Acumen study provides for the usage of localities used to pay other Medicare providers it is a viable option that should be strongly considered. In addition, this option would assure uniformity and provide for a common base for updates across all types of providers.

The AMCNO physician leadership applauds CMS for contracting with Acumen to review this issue. Through their study, Acumen has demonstrated that there is a need to change the current GPCI locality configuration. We hope that CMS will act upon the information provided by Acumen and include an item in the 2009 physician update to implement one of the options.

In addition, in the event that CMS proposes changes to the locality configuration and CMS does pursue the concept of conducting town hall meetings, we hope that CMS will consider conducting a town hall meeting in the Northern Ohio area so that the medical community in this part of Ohio can voice their opinion on this important matter. In addition, the AMCNO would welcome the opportunity to meet with representatives from CMS personally to discuss this matter further. If you have any questions regarding our comments please feel free to contact me through the AMCNO offices at 216-520-1000.

Sincerely,
Raymond J. Scheetz, Jr., MD, President
Enclosures/Attachments

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Imaging of Coronary Atherosclerotic Disease with Computed Tomography (CCTA). Appropriate Indications and Impact on Clinical Management.

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Despite advances in the treatment of acute and chronic complications, atherosclerotic disease and its cardiovascular as well as cerebrovascular complications remain the leading cause of death in men and women in the US. It is particularly concerning that many of the risk factors including sedentary lifestyle, obesity, and diabetes are increasingly prevalent in adult but also pediatric populations. This national trend is certainly seen in Ohio. Future reduction of this disease burden will require early disease identification and prevention, which in large parts will rely on assessment of clinical risk factors and education about lifestyle changes including diet and exercise.

In addition to clinical history and physical examination, cardiac imaging plays an established part in the management of all stages of ischemic heart disease. Examples are the assessment of ventricular function with echocardiography, myocardial ischemia with stress-testing, and significant luminal coronary stenosis with conventional angiography. While these diagnostic modalities have traditionally been focused on advanced disease stages, there is increasing interest in the diagnosis of early stages and the prognostic value of imaging. Examples are the assessment of diastolic dysfunction with echocardiography, the prognostic value of nuclear imaging, and carotid ultrasound or CT calcium scoring for assessment of atherosclerotic plaque burden (1–4).

Over the last few years, coronary computed tomography (CCTA) has emerged as a non-invasive cardiovascular imaging modality (5,6). It became feasible after implementation of two key technical advances, spiral ECG-gated scanning and multislice technology, which allowed fast acquisition of multiple image slices per tube/gantry rotation (7). Current standard, state-of-the-art scanners simultaneously acquire 64 image slices in a

spiral acquisition mode. Data are acquired throughout the entire cardiac cycle, but only data from specific periods of the cardiac cycle are reconstructed by retrospective referencing to the ECG signal (“spiral scanning with retrospective ECG gating”). Although modern scanners reduce the tube current outside the selected phase (“dose-modulation”), the continuous X-ray exposure during the entire cardiac cycle results in significant patient radiation dose (8). While the long-term effect of CT radiation is unclear, there is need for reduction of radiation dose (9,10). Significant reduction in radiation dose has recently become possible with prospective data acquisition, which is performed by selectively turning the X-ray tube on only in a selected cardiac phase, triggered by the ECG signal (“prospective triggering”). In a recent paper, using a clinical 64-slice system, coronary imaging with prospective ECG gating resulted in diagnostic image quality with a low mean radiation dose (2.1 ± 0.6 mSV; range 1.1–3.0 mSV) (11). The results were highly heart rate dependent and therefore aggressive heart rate lowering with beta-blockers was necessary. Nondiagnostic segments were found in 23% of patients, many related to step-artifact secondary to table motion. Table motion is still necessary

with current 64-slice scanners, which require 3–5 gantry rotations to acquire the entire coronary tree. A significant further increase in the number of slices has been accomplished with the introduction of 320-slice scanners, which allow imaging of the entire heart in one rotation, therefore eliminating artifacts related to the movement of the patient table (12). Other novel approaches include faster gantry rotation times, dual-source technology (two X-ray tubes to achieve a nearly two-fold improved temporal resolution of 83 ms), and more efficient detectors systems (13).

Coronary CTA has undergone significant clinical validation and its feasibility and diagnostic performance for the assessment of luminal stenosis has been evaluated against conventional angiography (14,15). It has been demonstrated, that significant luminal stenosis can be excluded with high negative predictive value. The positive predictive value for the detection of stenotic lesions is reduced by stenosis overestimation due to artifact associated with advanced, calcified atherosclerotic lesions. While future systems will improve this, it is critical to remember that the correlation between anatomic stenosis severity, regardless if assessed with conventional or CT angiography, and hemodynamic lesion significance is limited (16). Therefore, CTA alone will not be sufficient for the precise assessment of highly stenotic lesions and planning of percutaneous coronary interventions (PCI). On the other hand it is important to consider that tomographic imaging allows simultaneous assessment of the plaque within the vessel wall (17–20). Recent studies suggest that noncalcified and mixed calcified plaque may correspond with more unstable lesions (21,22).

In symptomatic intermediate risk-populations, where CTA is considered clinically indicated, comprehensive assessment of presence, location, and number of stenosis, but also location, presence and characteristics of plaque allow to identify patterns of disease manifestation. These include absence of any disease (absence of plaque and stenosis), nonobstructive disease (presence of plaque in the absence of significant stenosis), and suspected stenotic disease (presence of plaque and luminal stenosis). CTA has demonstrated the ability to describe these patterns of atherosclerotic disease and their prognostic value for all-cause mortality (23,24). Identification of these clinical

patterns can guide further management, including the need for functional stress testing, cardiac catheterization, and aggressiveness of risk factor modification, but their incremental value needs to be further evaluated.

Professional societies including the ACC and ACR have developed and published consensus guidelines, which provide a framework for clinical application for CCTA (25,26). These guidelines suggest that coronary CTA is appropriate in selected symptomatic patients with intermediate pretest risk, in whom CTA has a high likelihood to avoid cardiac catheterization. Other indications for CTA are coronary CTA of patients with chest pain in the emergency department (27), bypass graft imaging, and anomalous coronary arteries.

In summary, cardiovascular computed tomography is an emerging and fascinating aspect of coronary imaging. However, the clinical impact on preventive and therapeutic interventions in patients with CAD is incompletely understood. Further careful evaluation is necessary, and the use of coronary CTA should be based on emerging scientific data, considering alternative imaging strategies. ■

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Editor's note: The AMCNO welcomes article submissions from our members. The Northern Ohio Physician does not obtain medical reviews on articles submitted for publication.

AMCNO members interested in submitting an article for publication in the magazine may contact Ms. Debbie Blonski at the AMCNO offices at (216) 520-1000, ext. 102.

AMCNO Valentine Wine

The Academy of Medicine of Cleveland & Northern Ohio

Membership Committee cordially invites

physician members, residents, medical students and spouses

to attend our 2009 wine-tasting event.

This is the perfect opportunity for you to celebrate

Valentine's Day AND mingle with your colleagues.

♥ Hors D'oeuvres

♥ A fine selection of wines

♥ A dialogue with a local wine sommelier

La Cave du Vin

2785 Euclid Heights Blvd. ♥ Cleveland Heights, OH

Sunday, February 15, 2009

5:00 to 7:00 PM

♥ Cost: \$30 per members/spouses

\$15 residents & medical students

RSVP by Feb. 13th to Linda Hale

Phone (216) 520-1000 ♥ Fax (216) 520-0999

Mail 6100 Oak Tree Blvd., #440 Independence OH 44131

IF PAYING BY CREDIT CARD ACCT # _____

EXP. DATE _____

NAME _____

GUEST _____

AMCNO ACTIVITIES

CUYAHOGA COMMUNITY COLLEGE AMCNO DISCOUNTED MEDICAL PRACTICE SEMINARS AND COURSES Spring 2009

To obtain your AMCNO discount code:
Call The Academy of Medicine Cleveland & Northern Ohio at (216) 520-1000
Then, call Cuyahoga Community College to register at (216) 987-3075

MEDICAL TERMINOLOGY

Review the structure and composition of the human body and organ functions while learning helpful methods for breaking down medical terms and meaning. Review word structure, visual identification of terms, spelling, definition, and pronunciations. Flash cards and CD-ROM practice to enhance comprehension of medical terms.

Note: Required textbook is "Medical Terminology: A Living Language" 4th Ed. ISBN 978-0-13-158998-8

CRN: 17007	CCE	1/13/09 – 2/26/09(T,R only)	6:00pm – 8:30pm	\$253
CRN: 17005	CCW	1/5/09 – 2/23/09(M,W only)	6:00pm – 8:30pm	\$253
CRN: 17009	UTC	1/12/09 – 3/2/09(M,W only)	9:00am – 11:30am	\$253

ACCELERATED AAPC PROFESSIONAL MEDICAL CODING CURRICULUM

Prerequisite: Students must submit letters from employers verifying 2 years experience in medical coding on the first day of class. This 36- hour program is formatted for the experienced coder summarizing the more basic concepts of the Professional Medical Coding Curriculum while emphasizing the more complex issues.

Note: This course will require daily home-study. Current year CPT and ICD-9-CM Coding manuals required. AAPC Membership and Step by Step textbook included.

CRN: 17014	CCE	1/10/09 – 3/7/09(Sat only)	9:00am – 1:00pm	\$850
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MEDICAL BILLING REIMBURSEMENT

Enhance your billing skills, or take it as part of the Patient Access Specialist training program to prepare for your professional certification. Gain proficiency in insurance verification, eligibility and billing for Medicare, Medicaid and commercial insurance covered medical services.

Note: Required Textbook is Medical Insurance An Integrated Claims Process Approach; ISBN 9780073256450 and the Workbook to accompany the text ISBN 9780073402109

CRN: 17020	UTC	2/10/09 – 3/5/09 (T,R only)	9:00am – Noon	\$282
CRN: 17022	CCE	3/4/09 – 4/22/09 (W only)	6:00pm – 9:00pm	\$282

EFFECTIVE DOCUMENTATION: THE ULTIMATE CHART AUDITING GUIDE

This advanced chart auditing workshop will provide the tools needed to score your records the way Medicare would if they performed an audit. This workshop will provide the experienced coder with innovative concepts to help assure your records and audit processes are compliant with current federal guidelines.

CRN: 18413	CCE	Feb 11	9:00am – Noon	\$249
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EMERGENCY PROCEDURES: WHAT PRACTICE CODERS NEED TO KNOW

Review all E&M CPT codes for physicians' billing for private specialty practices and emergency rooms. Discussion of codes that are often missed and why. The class will include a discussion of the importance of modifiers — when and why they should be used.

CRN: 17740	CCW	Mar 11	8:30am – 11:30am	\$139
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CARDIOLOGY CODING

Review the anatomy of the heart, its cardiovascular and electrical system. A brief description of the most common cardiac-related conditions will be addressed as well as the types of non-invasive and invasive testing used to diagnose and/or treat these conditions. Students will be given examples of specific coding scenarios and the common modifiers used in cardiology coding.

CRN: 17738	CCW	Mar 20	8:30am – 11:30am	\$139
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DENIALS AND APPEALS: AN INTERACTIVE DISCUSSION FOR MEDICAL CODERS

Have you been denied? Would you like to know the proper way to appeal and have the denial reversed? Come and listen in as your peers discuss best practices using real situations. Bring your questions.

CRN: 18870	CCE	Apr 1	9:00am – Noon	\$139
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EMERGENCY PROCEDURES: WHAT PRACTICE CODERS NEED TO KNOW

CRN: 17742	CCE	Apr 22	8:30am – 11:30am	\$139
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GENERAL MEDICINE CODING AND NON-INVASIVE TESTING

This program will take an in-depth look at the Medicine Section of the CPT-4 manual, including a brief look at some invasive coding procedures such as immunizations and vaccinations. Emphasis will be placed on non-invasive diagnostic testing in many areas of general and specialized medicine.

CRN: 17736	CCE	May 1	8:30am – 11:30am	\$139
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ICD – 9- CM FUNDAMENTALS AND MORE

Strengthen your ICD-9-CM diagnostic coding skills and reduce your claims denials. In a hands-on, interactive session, you will work on multiple coding exercises and have your coding questions answered. Explore the construction of the ICD-9-CM Code book so that you truly understand how to use this reference guide when coding for compliance. Bring: 2008 ICD-9-CM Coding Manual; a medical dictionary would also be helpful.

CRN: 17727	CCE	May 6	9:00am – 3:30pm	\$179
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CPT CODING FUNDAMENTALS AND MORE!

A companion class to the ICD-9-CM Fundamentals program! This CPT coding seminar will strengthen your procedural coding skills and reduce your claims denials. In a hands-on, interactive session, you will work on multiple coding exercises with a focus on accuracy and compliance. Explore the construction of the CPT-4 Code book so that you truly understand how to use this reference guide. Coding scenarios will increase in complexity as the day progresses. Bring: 2008 CPT-4 Coding Manual to class; a medical dictionary would also be helpful.

CRN: 17715	CCE	May 20	9:00am – 3:30pm	\$179
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CCS CERTIFICATION EXAM REVIEW

Prerequisite: Hospital Coding experience or academic coursework, in hospital/technical coding. An intensive review of the CCS exam using timed mock test questions and answer review. Focus on your exam preparation while you learn from your coding errors and from others in the class. This convenient Saturday workshop will supplement your studies and help you tie together the important elements of this Certification Exam preparation.

Note: Required text: Current Year Professional Review Guide for CCS Exam/CD ROM Current Year CPT Coding Manual and ICD-9-CM Volumes I, II

CRN: 17015	CCE	Jan 31	9:00am – 2:45pm	\$120
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For more information, contact Linda Hale at AMCNO at lhale@amcnoma.org
Or by calling AMCNO at (216) 520-1000

CCE – Corporate College East, 4400 Richmond Road, Warrensville Heights, OH 44128
CCW – Corporate College West, 25425 Center Ridge Road, Westlake, OH 44145
UTC – Unified Technologies Center, 2415 Woodland Avenue, Cleveland, OH 44115

24th Annual Mini-Internship Program Continues Tradition of Excellence

The Academy of Medicine of Cleveland & Northern Ohio was pleased to facilitate the 24th Annual Mini-Internship Program October 20 through 22, with both physician and intern participants relating the many benefits of the two-day shadowing event. From office visits to surgery, trauma care to hospital rounds, interns experienced a "Day in the Life" of local physicians, an unparalleled look at the practice of medicine in today's healthcare arena. The response from both community leaders and member physicians to participate in the 2008 program was impressive. The program kicked off with a brief orientation where interns and their respective physician faculty met, last minute important information was exchanged, and program goals were shared by Chairman **William Seitz, Jr., MD**. Afterward interns then received HIPAA training. A debriefing dinner was held at the end of the event where a lively exchange of comments and perspectives about the experience occurred between interns and physicians. Judging from comments made at this dinner, the Mini-Internship was an extraordinary experience for all involved. The AMCNO expresses its sincerest appreciation to both the doctors and community members who committed their time and effort to make this very special program a true success year after year. For more information on Mini-Internship opportunities, contact Debbie Blonski at (216) 520-1000 ext. 102.



The 2008 interns gather for a group photo during the orientation (interns in white coats l to r) – Mr. Douglas Anderson, City Councilman Joe Santiago, City Councilwoman Phyllis Cleveland, State Representative Michael DeBose, Sister Diana Stano, and Ms. Amy Leopard.

"The physician's total focus is on the patient and getting the patient well, and the analysis that goes into understanding what is going on."

Doug Anderson, Chief Policy Officer, Ohio Department of Insurance



Dr. Seitz provides an overview of the program to the mini-internship participants.

"Sr. Diana was great to have. She was part of the team, pitching in and asking questions."

Patricia Kellner, MD

"This experience reminded me of how much I love teaching. It helped me look at mundane things in a different way."

Matt Levy, MD

"It was a beneficial experience for me. This was my first year and I would like to do this again. I know of other doctors who would like to participate."

Charles Modlin, Jr., MD

"As a teacher, the interns are like first-year residents and that makes it fun for me."

Tom Abelson, MD

"The technology was just incredible! I was amazed that half the time is spent with technology and half with patient care."

Amy Leopard, Partner, Walter & Haverfield, LLP



Dr. Seitz confers with physicians participating in the program prior to the beginning of the orientation.

"If I can say one thing it's 'access' — poor people have access to healthcare. They turn nobody away in the treatment center."

Michael DeBose, Ohio House of Representatives, 12th House District



Dr. Modlin (right) discusses the program with Ohio State Representative Michael DeBose.

"I observed that patient care and well-being is the primary focus, that technology seems to have added so much to what a doctor can do, and that each doctor works long and hard. It was a wonderful experience."

Sr. Diana Stano, President, Ursuline College

2008 Physician Participants

William Seitz Jr., MD, Chairman
Tom Abelson, MD
Diane Butler, MD
John Carl, MD
Wanda Cruz-Knight, MD
Sam Friedlander, MD
Antony George, MD
Gerard Isenberg, MD
Paul Janicki, MD
Patricia Kellner, MD

Shashidhar Kusuma, MD
Matthew Levy, MD
James H. Liu, MD
Srinivas Merugu, MD
Charles Modlin, MD
Douglas Rogers, MD
Robert Rogoff, MD
Juan Sanabria, MD
Thomas Steinemann, MD
Mirfee Ungier, MD

2008 Program Interns

Doug Anderson, Chief Policy Officer, Ohio Department of Insurance
Phyllis Cleveland, Cleveland City Council, Ward 5
Michael DeBose, Ohio House of Representatives, 12th House District

Amy Leopard, Partner, Walter & Haverfield LLP
Joe Santiago, Cleveland City Council, Ward 14
Sister Diana Stano, President, Ursuline College

AMCNO ACTIVITIES



Dr. Tom Abelson (left) and Dr. William Seitz, Jr., present Ms. Leopard with her certificate.



Dr. Seitz spends a moment with intern Mr. Douglas Anderson from the Ohio Department of Insurance.



Councilman Joe Santiago confers with Dr. Mirfee Ungier during the orientation.



Mr. Douglas Anderson dons his AMCNO white coat while talking with Dr. Tom Abelson.



Sister Diana Stano receives her certificate from (l to r) Dr. Paul Janicki, Dr. Patricia Kellner and Dr. Tom Abelson.



Participants share notes during the orientation.



Ohio State Representative Michael DeBose receives his certificate from Dr. William Seitz, Jr., and Dr. Thomas Steinemann.



Mr. Douglas Anderson poses with Dr. Matthew Levy (left) and Dr. William Seitz, Jr.



Sister Diana Stano greets Dr. Patricia Kellner at the debriefing dinner.



Dr. Paul Janicki (left) and Dr. Tom Abelson discuss the program with Sister Diana Stano.



Three of the interns pose with Dr. William Seitz, Jr., (l to r) Councilman Joe Santiago, Councilwoman Phyllis Cleveland and Representative Michael DeBose.



Dr. Paul Janicki shares a laugh with Sister Diana Stano during the orientation.



Mini-internship participants share their experiences during the debriefing dinner.



- #1 Investment Strategies
- #2 Appropriate Insurance Coverage
- #3 Credit Management

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