

## AMCNO President Participates in AARP Health Care Forum

In June AMCNO President **Dr. Anthony Bacevice, Jr.** was asked to present to more than 300 AARP members on the topic of "Health Reform – A Shared Responsibility." Also included on the panel were representatives of AARP, a representative from the Service Employees International Union (SEIU) and an AARP Ohio health reform issue specialist.

Dr. Bacevice focused his remarks on areas of interest to the AMCNO and its members such as the need to replace the sustainable growth rate (SGR) and the manner in which physicians are currently reimbursed under the Medicare program. He stressed the need to continue to look for alternatives to handling medical liability claims, noting that the current system is not cost-effective. Dr. Bacevice also outlined how physician quality is currently

measured and the AMCNO involvement in legislation in Ohio that would prevent insurers from ranking physicians solely on economic criteria designed to persuade a consumer to select one physician over another based upon claims data and costs. Dr. Bacevice also provided the group with comments regarding the current discussion around the development of electronic

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*Dr. Anthony Bacevice, Jr., AMCNO President, delivers his comments to the capacity crowd at the AARP forum. Also pictured – panelists representing the SEIU and AARP.*



## AMCNO President Delivers Welcome Address at Medical School Commencement Award Ceremony

**Dr. Anthony Bacevice, Jr.**, president of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), spoke on behalf of the organization at this year's Case Western Reserve University School of Medicine commencement awards ceremony. The awards ceremony was held on Saturday, May 16 and included remarks by Dr. Bacevice to the graduating students. Dr. Bacevice was also present at the commencement ceremony the following day at Severance Hall. Of note was the fact that 2009 was the first year that the commencement included a graduating class of medical students from the Cleveland Clinic Lerner College of Medicine.

One of the many awards given out at the ceremony was presented by AMCNO Past President **Dr. Richard B. Fratianne**. The award is given in memory of his mother

and is known as The Betty Jean Fratianne, M.D., Student Award which is given to a senior student who best exemplifies a

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*Dr. Anthony Bacevice, Jr., AMCNO President, spends a moment with the Dean of CWRU School of Medicine, Dr. Pamela Davis.*

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# COMMUNITY ACTIVITIES

## AMCNO President Participates in AARP Health Care Forum

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health records, the costs involved and the need for interoperability. He touched on the issue of the medical home model and the AMCNO involvement in projects at the regional and state levels on these issues. Finally, Dr. Bacevice commented on the need for patients, inclusive of the Medicare population and AARP members, to take an active role in their health care and focus on wellness and disease prevention, in particular by embracing healthy lifestyles and prevention initiatives when possible.

The SEIU representative noted that his organization would like to see health care reform that makes health care coverage affordable and attainable for everyone inclusive of fostering choice in the market with a public health care option. The union also stressed the need to address the issue of the costs involved in long-term care.

AARP's presentation focused on their health reform campaign which outlines six priorities – guaranteeing access to affordable coverage for Americans age 50-64; closing the Medicare Part D coverage gap; creating a Medicare transition benefit to help people return to their homes after a hospital stay and prevent readmissions; increase federal funding and eligibility for home- and community-based services through Medicaid so older Americans can remain at home and avoid costly hospitalizations; create a pathway for the approval of generic drugs to reduce the price of treatments; and improving the Medicare Savings Programs and the Part D Low Income Subsidy so more Americans can afford health care and prescription drugs.

Several questions fielded by the panel dealt with what kind of payment system might emerge at the federal level. All of the panelists agreed that something more than likely will happen on the issue of health reform in the near future noting that a public option may or may not be included. AARP noted that



A crowd of over 300 attendees heard the AMCNO presentation regarding health care reform issues.

everyone should keep in mind there is a big difference between a single payor and universal health care. Dr. Bacevice commented it will be very important that any plan that emerges retains the patient/physician relationship with the ability of the physician to continue to determine the appropriate care for their patient – rather than legislating how to practice medicine.

The AMCNO continues to monitor the debate at the federal level on health care reform while working at both the regional and state levels on this key issue. ■

## AMCNO President Delivers Welcome Address at Medical School Commencement Award Ceremony

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commitment to the compassionate care of patients, volunteer service and sensitivity to the needs of the poor, the elderly and the handicapped. Another student received an award bearing the name of another past president of the AMCNO, **Dr. Ted Castele**. This award, known as the Ted Castele, M.D., Award for Civic Professionalism is given to a student who most exemplifies the passion for healing societal problems.

One student from the 2009 graduating class was the first recipient from the Case Medical School to receive the American Medical Association Foundation Minority Scholars Award. This is an effort by the AMA to promote diversity and help with the rapidly rising cost of medical education. This year the AMA presented 12 outstanding medical students from across the country with \$10,000 Minority Scholars Awards. The awards recognize scholastic achievement, financial need and personal commitment to improving minority health among first- or second-year medical students in groups defined as "historically underrepresented" in the medical

profession. The Minority Scholars Awards are given in collaboration with the AMA Minority Affairs Consortium, with support from Pfizer Inc.

Dr. Bacevice presented the graduates with a "Welcome to the Profession" address which offered some thoughts on what they might expect as they continue their training and encouraged the students to become involved in their community and organized medicine.

The AMCNO congratulates all of the 2009 medical school graduates. The AMCNO has represented the physicians



Dr. Bacevice talks with AMCNO Past President Dr. Richard Fratianne prior to the award ceremony.

in this region for over 185 years and we were proud to be a participant in these events. ■

## NORTHERN OHIO PHYSICIAN

### THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

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## Update – Novel Influenza A (H1N1) Virus

*Karen Seidman, RN, MPH, Consultant, Cuyahoga County Board of Health*

*Rebecca Hysing, MPH, Regional Public Health Preparedness Coordinator, Cuyahoga County Board of Health*

Suddenly, an influenza pandemic is not an abstraction. In March and April, 2009, Mexico reported the presence of increased levels of respiratory disease, with patients experiencing pneumonia, some of whom died. On April 21, 2009, the Centers for Disease Control and Prevention (CDC) reported two cases of infection with a previously unknown influenza virus, isolated from children in Southern California. The virus was identified as novel influenza A (H1N1), a virus containing genetic segments from a human influenza virus, an avian influenza virus and two swine influenza viruses, likely the result of reassortment (antigenic shift). Soon, cases of novel influenza A (H1N1) infection were being reported throughout the United States and in other countries.

During the last week of April, Ohio reported its first confirmed case, identified as a 9-year-old male living in Lorain County. About a week later two cases from Cuyahoga County were confirmed. The local health departments, in conjunction with the Cuyahoga County Emergency Management Agency, opened the local Emergency Operations Center during the last weekend of April. Public health officials and other health care providers were frequently interviewed by the local news media. Staff members at the local health departments fielded questions from concerned residents. Health care providers called the health departments with questions about testing and routing specimens. Initially, the local health departments hosted two daily conference calls for local stakeholders. As the situation stabilized, these calls were reduced to one call a day and then eliminated. The local health departments have continued their usual communication with community partners, answering questions, sharing information and reinforcing previous planning. As planning gaps were identified, changes have been made.

Initially CDC recommended school closure for individual schools if a student or a staff member was diagnosed with novel influenza A (H1N1). Locally some schools decided to close when administrators heard that someone connected with the school might be infected with this virus. As this is being written, all schools in Cuyahoga County have returned to normal operations.

The currently circulating novel influenza A (H1N1) virus is sensitive to the neuraminidase inhibitor antiviral medicines zanamivir (Relenza®) and oseltamivir

(Tamiflu®), but is resistant to amantadine (Symmetrel®) and rimantadine (Flumadine®). There is evidence that the prompt initiation of antiviral treatment, within 48 hours after the start of symptoms, may lessen the risk of complications and possibly shorten the duration of symptoms. Health officials in Cuyahoga County have recently updated plans and procedures to receive, inventory, store, allocate and track antiviral and medical countermeasures, including personal protective equipment (PPE) and other supplies if needed. In addition, local health departments, using grant funding from the Ohio Department of Health, are exploring processes for dispensing and distributing antiviral medicines to nonhospitalized people during an influenza pandemic. In May, questionnaires were sent to local physicians and to home health care agencies to assess their ability to assist with this project.

Deciding the appropriate treatment may become more complicated during the 2009-2010 influenza season. The currently circulating seasonal influenza virus H1N1 has become increasingly resistant to oseltamivir, with over 99% of seasonal H1N1 samples tested this flu season by CDC labs found to be resistant to oseltamivir. This is an increase from the 12% of tested samples showing resistance to oseltamivir during the 2007-2008 flu season. Current treatment recommendations can be found at <http://www.pandemicflu.gov/vaccine/medantivirals.html>

Public health officials are concerned that novel influenza A (H1N1) could further mutate during the influenza season in the Southern Hemisphere and reappear in the Northern Hemisphere next fall as a more

virulent virus. Avian influenza virus H5N1, circulating in Asia, Europe and Africa, continues to be a pandemic threat as well. On May 22 the World Health Organization (WHO) reported five recently confirmed human cases of H5N1 infection in Egypt, all in young children, ages 3 and 4 years. As with other cases of H5N1 infection in humans, all the infected children had had recent contact with sick and/or dead poultry.

CDC, working in conjunction with WHO, has initiated preparation for production of a vaccine for novel influenza A (H1N1). Limited supplies of the vaccine are expected to be available no earlier than this fall. Public health officials currently are determining the composition of the vaccine, the advantage of using adjuvants, etc., as well as attempting to balance the production of a vaccine for novel influenza A (H1N1) while simultaneously producing seasonal flu vaccine.

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## Update from the Investing in Tobacco-Free Youth Coalition

By Shelly Kiser, Director of Advocacy, American Lung Association of Ohio

Tobacco candy is the term some people are using to describe a new form of tobacco product that is mint-flavored and looks like a Tic Tac. RJ Reynolds, the manufacturer, calls it Camel Orbs, and it's being test marketed in Columbus, Ohio. The product is made of finely ground tobacco and contains nicotine, but looks like a mint and comes in a package that resembles a mint tin so closely that it's not difficult to imagine that kids could use it undetected in front of parents or teachers.

Camel Orbs is just one of the many smokeless tobacco products that is contributing to the surge in use of non-cigarette forms of tobacco or "other tobacco products" (OTP) by adults and children here in Ohio and around the country. In addition to these new spit-free forms of tobacco, the use of spit/chew tobacco, cigars, little cigars, pipe, and hookah is on the rise, while the rate of cigarette use declines. The table below shows the rates of increase in the use of some OTP products compared to the decline in the usage rates of cigarettes.

### 2002-2007

Small cigars:	+116.9%
Large cigars:	+5.2%
Snuff:	+24.0%
Roll Your Own:	+62.7%
Cigarettes:	-13.1%

Recent studies have also found that hookah smoking rates among high school and college students are similar to cigarette smoking rates. No studies of the new spit-free smokeless tobacco are available yet, but anecdotally, we know that students are reporting their use by classmates, and janitors are finding related refuse in trash cans at schools.

As with Camel Orbs, other non-cigarette forms of tobacco are often candy flavored and come in kid-friendly packaging. Spit/chew tobacco comes in grape, cherry, and sour apple; hookah tobacco comes in bubble gum and cotton candy; and little cigars are available in watermelon, chocolate, and peach, among other flavors. They are frequently sold and displayed in convenience stores near candy and snacks.

One of the other factors behind the rise in use of these non-cigarette forms of tobacco is the price differential. When the cigarette tax was raised in 2003 and 2005 in Ohio, the legislature failed to also raise the OTP

tax. Therefore, the tax on OTP is less than half the cigarette tax, when put in comparable terms. Since youth are the most price-sensitive consumers, the lower tax makes them especially appealing. Small, flavored cigars sell for less than a dollar, sometimes for only a quarter.

The Investing in Tobacco-Free Youth Coalition, with over 65 members, including the **Academy of Medicine of Cleveland and Northeast Ohio**, has started a campaign to combat this growing problem in our state. The Coalition is asking the legislature to correct the inequality between the tobacco taxes so that all tobacco is taxed at the same rate. Doing so would bring the tax from its current 17% of wholesale price to 55% of wholesale price, generating approximately \$50 million a year for tobacco prevention and cessation programs. It would also decrease the overall consumption of other tobacco products by over 13%, and 25% fewer youth would use the products—a dramatic decline.

Adequate funding for tobacco prevention and cessation is not unreasonable. Our funding request is barely sufficient to combat the \$2 million a day that the tobacco industry spends marketing its product in Ohio. It also pales in comparison to the almost \$1 billion that Ohio receives every year from its cigarette tax. The CDC actually recommends that Ohio spend \$145 million for tobacco prevention and cessation annually; this equalization would get us started toward that goal.

The increased funding would allow Ohio to bring back the many high-quality, science-based programs that were recently cancelled due to lack of funding, including in-school prevention programs; community tobacco prevention coalitions; assistance for disproportionately impacted populations; youth outreach and counter marketing; and

cessation assistance. In this tight economy, free or discounted cessation services are needed more than ever.

Reducing smoking rates directly through the equalization and by bringing back programs will reduce the budget and save healthcare costs and taxpayer dollars. Smoking costs Ohio over \$9 billion every year. Ohioans pay over \$4 billion in healthcare costs annually; \$1.4 billion of that amount is the portion covered by the state Medicaid program. The average Ohio household pays \$629 in state and federal taxes related to smoking-caused government expenditures annually.

The coalition has focused on educating the legislature about the problem that OTP products pose to Ohioans, especially our youth. This winter we sent each legislator a series of eight newsletters on the OTP problem and how funding cuts have impacted Ohioans.

The Campaign for Tobacco-Free Kids, a member of the coalition, arranged for the Robert Wood Johnson Foundation to fund ads that ran on Columbus and Cleveland radio stations over a two-week period. The ads were educational in nature and talked about the OTP problem and how Ohio lawmakers could be doing more to prevent it.

Legislatively, we have had interest in our proposal. Last year Representative Tyrone Yates from Cincinnati introduced a bill to equalize the taxes and fund tobacco prevention and cessation. Unfortunately, it was not considered before the session ended.

Early this year, Senators Dale Miller, Ray Miller, and Joe Schiavoni introduced Senate Bill 37 which would equalize the other tobacco products (OTP) tax with the cigarette tax and give most of the money to tobacco prevention and cessation. So far, that bill has not had a hearing. The legislature's current focus is the state budget for the next two years, which must be finalized by June 30.

The Coalition will continue to push for legislation as part of the budget as it progresses in the legislature, and barring its inclusion, as a stand-alone bill.

**Editor's note:** *The AMCNO support SB 37 and we have sent a letter to the chairman of the Senate committee voicing our support of the bill.*

## Recurrent Acute Pancreatitis (RAP): What to do?

Gerard Isenberg, M.D., FASGE, AGAF, FACP, Associate Chief, Division of Gastroenterology, Associate Professor of Medicine, University Hospitals Case Medical Center, Case Western Reserve University

A 55-year-old woman presents to your clinic; she was recently discharged from the hospital with her second attack of acute pancreatitis. She states that the physicians in the hospital could not figure out what caused her attacks, but she quickly recovered after a brief 3 – 4 day stay in the hospital with each episode. What should be your next steps?

If you happen to reside in Indianapolis, you most likely would be referring her for an ERCP (endoscopic retrograde cholangiopancreatography) with sphincter of Oddi manometry (SOM). However, there are little data that sphincter of Oddi dysfunction causes RAP, and furthermore, no conclusive data that biliary or pancreatic sphincterotomy in patients with elevated sphincter pressures results in a cure from recurrent attacks. If you happen to reside in Charleston, you most likely would be referring her for a pancreatic EUS (endoscopic ultrasound) to evaluate for anatomic causes. However, the yield for detecting a cause for RAP on EUS is not high. Since you reside in Cleveland where both of these procedures are available, should you refer her for one of these tests or should you also consider other possibilities as well?

Space limitations preclude an in-depth discussion, but herein I will touch on the essential points. Pancreatitis accounts for 220,000 hospitalizations per year in the U.S. The diagnosis of acute pancreatitis requires 2 of 3 criteria: (1) upper abdominal pain, (2) elevations of amylase and lipase at least 3 times normal, and (3) radiographic evidence of pancreatic inflammation. Remember that amylase elevations in serum and urine occur in many conditions other than pancreatitis. In addition, many patients with renal failure have asymptomatic elevations in pancreatic enzyme levels (due to poor clearance); they do not necessarily have pancreatitis.

Approximately 25% of patients who have had an attack of acute pancreatitis have a recurrence. The two most common etiologic factors are alcohol and cholelithiasis. Some patients will deny alcohol use, and it isn't until a family member reveals this information that a diagnosis is established. Remember, too, that a negative gallbladder

ultrasound does not rule out microlithiasis (sludge) as a cause for RAP. If a patient has associated liver function abnormalities with their pancreatitis episodes, consideration should be made to pursue an ERCP with

biliary fluid aspiration for crystal analysis and biliary sphincterotomy. A cholecystectomy should also be considered.

Hypertriglyceridemia and hypercalcemia are associated with RAP. Remember that patients who are fasting (NPO) may have falsely low triglyceride levels, and thus repeating the triglyceride level after recovery may reveal the potential etiology.

In patients with RAP without an obvious cause the differential diagnosis should, of course, be expanded. Potential etiologies are listed in Tables 1 and 2 below. Yet, even after an extensive search, up to 20% of patients with RAP do not have an identifiable cause.

**Table 1. Potential etiologies of recurrent acute pancreatitis.**

Common	Uncommon	Rare
Gallstones, including microlithiasis	Sphincter of Oddi dysfunction (controversial)	Infections (including mumps, cytomegalovirus, <i>Cryptosporidium</i> , <i>Mycobacterium avium</i> complex, <i>Microsporidium</i> , <i>Isospora</i> , <i>coxsackievirus</i> , echovirus, parasites)
Alcohol	Hypercalcemia	Autoimmune pancreatitis
Hypertriglyceridemia (> 1000 mg/dL)	Pancreas divisum (controversial)	Choledochocoele/choledochal cysts
Trauma (particularly blunt abdominal trauma)	Hereditary pancreatitis	Anomalous pancreatico-biliary junction
Post-operative	Cystic fibrosis	Annular pancreas
Medications (see Table 2)	Vascular causes, including vasculitis, ischemic/hypoperfusion states such as post-cardiac surgery or related to ergotamine or cocaine, thrombotic thrombocytopenic purpura (TTP), hypercoagulable states, polyarteritis nodosa, systemic lupus erythematosus	Scorpion bite
Idiopathic	Connective tissue disorders	Insecticide poisoning
	Pancreatic neoplasms (adenocarcinoma, intraductal papillary mucinous neoplasm)	
	Pancreatic endocrine tumors	
	Ampullary malignancy	
	Periampullary diverticulum (controversial)	

**Table 2. Potential medications associated with recurrent acute pancreatitis.**

Strong	Weak	Uncertain
Estrogens (related to dose and development of hypertriglyceridemia)	Thiazide diuretics	Corticosteroids
Sulfonamides	Furosemide	Cyclosporin
Azathioprine	Angiotensin-converting enzyme inhibitors	Erythromycin
6-mercaptopurine	Tetracycline	5-aminosalicylic acid/sulfasalazine
Valproic acid	Metronidazole	Cimetidine
Didanosine	Acetaminophen	Methyl dopa
Pentamidine	Statins	Octreotide
Asparaginase	Isoretinoin	Zalcitabine
	Tamoxifen	

Approximately 2–5% of cases of acute pancreatitis are medication-related. Medications cause pancreatitis either by a hypersensitivity reaction or by the generation of a toxic metabolite, although in some cases it is not clear which of these mechanisms is operative.

If the patient is young or has other family members with pancreatic diseases or history of cystic fibrosis, genetic testing for hereditary pancreatitis and/or cystic fibrosis should be entertained. There are pros and cons to doing so. A definitive diagnosis may result in improved patient satisfaction, but there are no current therapies available to prevent future attacks in patients with hereditary pancreatitis. There are many genes that predispose to developing pancreatitis; three common ones are PRSS1 (cationic trypsinogen), SPINK1 (serine protease inhibitor, Kazal type 1), and CFTR (cystic fibrosis transmembrane conductance regulator). Due to the cumulative contributions of three genes in both dominant and recessive patterns, a patient may have genetically determined pancreatitis even if the family history is negative. In addition, mutations in more than one gene may be present. Even older patients may have cystic fibrosis heterozygosity that results in pancreatic problems without symptoms of respiratory disease. Genetic testing is offered by UH Case Medical Center and the Cleveland Clinic.

Autoimmune pancreatitis is being increasingly recognized. Often imaging studies reveal a bulky or diffusely enlarged pancreas. These patients might have associated autoimmune diseases such as scleroderma, Sjogren's disease, and thyroiditis. Increased serum levels of IgG subclass 4 and ANA are seen in this disease. Evaluation for autoimmune pancreatitis is important since this condition responds to corticosteroid therapy.

If the history, exam, labs, and standard imaging (e.g., right upper quadrant ultrasound and standard CT) fail to yield a potential diagnosis, structural causes can be assessed by pursuing first noninvasive imaging such as a high-resolution triple-phase CT scan of the pancreas and/or MRI of the pancreas with MRCP without and with secretin. Up to one in ten pancreatic cancers present with pancreatitis, pointing out the importance of evaluating for malignancy, particularly in patients over age 50. One advantage for CTs is that they are readily available in the community. MRI with MRCP

and secretin protocols are not, but they do not have the problem with ionizing radiation. A well-performed MRCP is particularly useful for identifying pancreas divisum. If either of these tests do not identify a cause, a referral to a gastroenterologist with pancreatic disease experience is often needed. Either a pancreatic EUS and/or ERCP with possible SOM can be performed. Pancreatic EUS is relatively safe, although the yield is variable and overall low. EUS can identify malignancies that may not be identified by noninvasive imaging and is likely the test of choice in older patients who are losing weight. Careful patient selection is required for ERCP with SOM as patients who undergo such procedures have a 20% risk for pancreatitis, and there have been a few deaths reported (from severe necrotizing pancreatitis) in those who undergo this procedure.

Many times, patients are simply observed; on occasion, the diagnosis eventually declares itself. But, the natural history of patients with RAP is unknown. Some patients have 2 episodes and then do not experience another episode until 10 years later. Others have recurring attacks and subsequently develop chronic pancreatitis.

How to handle patients with idiopathic RAP varies from center to center and from clinician to clinician. No single strategy is always preferred. The evaluation should be tailored to clinical factors such as the age of patient and frequency and severity of attacks. There remains substantial controversy and disagreement as to whether pancreas divisum and sphincter of Oddi dysfunction are causes of RAP. As noted at the beginning, even if ERCP is pursued and one of these diagnoses is found, the efficacy of endoscopic therapy is not well-delineated.

Until further data are forthcoming regarding the appropriate decision-tree to use for RAP, there is no one right way to evaluate RAP except to consider all of the aforementioned causes. And, that's a wrap on RAP...

**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.

## It's Time For Your Portfolio Check-Up

In light of the recent market volatility, it may be a good time to let a professional review your current portfolio(s) and offer a second opinion. A professional opinion will offer you ideas on how to reallocate some of your portfolio and allow you to consider the addition of alternative investments to help remove some of the portfolio volatility. Second opinions are always helpful.

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## Legislative Update

By Connor Patton, AMCNO lobbyist

### State Report

As the summer begins, things begin to heat up in Columbus. Three new candidates have emerged from the Republican front to challenge the Democrat statewide officeholders and one Democrat to challenge the lone Republican incumbent officeholder. First, from Cuyahoga County State Representative Josh Mandel has decided to throw his hat in the ring and run for State Treasurer against Kevin Boyce who was appointed by Governor Strickland to replace Richard Cordray. For Governor, John Kasich, a former Republican Columbus Congressman and Fox TV host has decided to challenge Ted Strickland. Next, in the State Auditor's race, a Hamilton County Commissioner David Pepper has emerged to be the Democratic candidate to run against incumbent State Auditor Mary Taylor. For Secretary of State, former Speaker of the Ohio House of Representatives and current State Senator Jon Husted has decided to seek the Secretary of State's office. Husted is from Montgomery County and will be seeking an open seat because of current Secretary of State Jennifer Brunner's decision to run for the U.S. Senate. No clear Democrat has been decided upon to run against Husted. The Secretary of State and Auditor races look to be very contentious. Both offices are on the apportionment board for the State of Ohio and the apportionment board draws the district lines for the Ohio General Assembly, which will be implemented in 2012.

The apportionment board is made up of the Governor, Auditor, Secretary of State, and a member of the majority party and minority party of the General Assembly. Currently, the Democrats control the apportionment board with a 3-2 edge. Usually the party that has the edge in drawing the lines for legislative districts will dominate politically for the next 10 years, so a lot is at stake for both parties in the 2010 election. Last, but not least on the statewide front, two Democrats look to square off in a very heated primary next May for the U.S. Senate. From Cuyahoga County, Lieutenant Governor Lee Fisher has decided to run and Secretary of State Jennifer Brunner who is from Franklin County is also seeking to be

the Democrat's choice to take back the U.S. Senate seat being vacated by George Voinovich. Rob Portman is the choice of the GOP. Portman is a former Congressman from Cincinnati and also served in two high level capacities with the Bush administration.

On the state budget front, a volatile climate has emerged primarily due to revenue estimate shortfalls, with clear differences between both chambers of the Ohio General Assembly and Governor Strickland's Administration on visions of what the state budget for fiscal years 2010-2011 should be. Ohio's Democratic-controlled House and Republican-controlled Senate each passed separate state budget proposals for 2010-11 that favor different agendas. A joint conference committee will have until June 30 to hammer out a balanced budget in time for the start of the 2010 fiscal year, on July 1.

Gov. Ted Strickland's budget proposal, issued in February, relied on \$7 billion in one-time revenues – mostly, federal stimulus funds – meaning that, barring a wildly unrealistic economic boom in the state over the next two years, the state would be \$7 billion short of extending ongoing programs into 2012-13.

House members decided to use rosier revenue estimates that were higher than those Governor Strickland used, to justify their adding another \$622 million in spending. The Senate managed to trim the \$54 billion House measure with \$459 million in cuts, but that still left a plan billions of dollars out of balance. The past year's dreadful economy has squeezed state income-tax revenues, and each updated estimate by the state budget office gets worse. After passage of the state budget through both chambers of the General Assembly revenue estimates said that the current budget period, ending June 30, will end with a deficit of more than \$2.4 billion.

Even after they patch the hole left by the current deficit, lawmakers have been left with the challenge and the reality that they can't expect future revenues to match the federal-stimulus subsidies.

The proposed hospital franchise fee, would cost Ohio's hospitals \$127 million, \$333 million or \$411 million, depending on whose plan and estimates one adopts. The state would impose the fee on hospitals and apply the revenue generated to the state's share of Medicaid. That money, combined with similar assessments on other health-care providers, would draw about \$2 billion in matching funds from the federal government for the state's Medicaid program.

In return, the governor proposed to raise Medicaid reimbursement rates to hospitals so that they recoup some of the franchise fees they pay. Under the governor's budget proposal, Ohio hospitals would pay \$598 million. They would receive \$187 million in increased Medicaid reimbursements, for a net loss of \$411 million.

The budget plan from the Ohio House initially would have reduced the net loss to hospitals to \$127 million, but recent estimates have raised the loss to \$333 million.

Whatever lawmakers choose to call it, the hospital industry believes the hospital assessment is a tax on every user of hospital services. It is a tax on the sick and the injured, on the insurers who cover them, and on the employers who pay health-insurance premiums to those insurers. The result of such a tax could mean job losses and service reductions at hospitals, resulting in lower-quality care for patients.

### Physician Ranking Update

The legislation spearheaded by the AMCNO dealing with the issue of physician ranking will be heard at the Ohio House Health Committee over the summer months. The AMCNO has prepared proponent testimony and plans to attend these hearings to show our strong support of the legislation.

## Legislator Spotlight Senator Capri S. Cafaro

I feel we must do all we can to make Ohio a better place to live, work and raise a family, and that is why improving health care for all Ohioans has been one of my top priorities since I joined the Ohio Senate. I have a particular interest in making improvements to Medicaid Managed Care so it is more responsive to the needs of doctors and patients.

In my role as the Senate's Minority Leader, I have been outspoken in calling for reforms in how Medicaid Managed Care operates in Ohio. Reforming Medicaid is no small task when you consider Ohio spends approximately \$13 billion annually on the program, which accounts for 23% of the State's budget. That makes Medicaid Ohio's largest single health care program covering 1.8 million Ohioans every month, including one million children.

I am especially concerned that it takes too long for Medicaid Managed Care to pay providers. Unless this issue is resolved, I fear we will see a reduction in the quality of care for needy Ohioans because fewer doctors will be willing to accept Medicaid patients. We must find a way to speed up the claim process so doctors receive their payments within a reasonable time frame.

Furthermore, we should reduce bureaucracy so physicians and their staffs do not waste

time with unnecessary paperwork and long delays for preauthorization. Their time should be spent treating patients, which would better address the health care needs of Ohioans.

I have been involved in discussions with key stakeholders to overhaul the program so administrative costs do not consume resources that should be going to Medicaid patients.

I look forward to continuing those conversations with interested groups to find solutions to the problems affecting Medicaid Managed Care because our doctors and citizens deserve a more responsive and efficient system.

Senator Capri S. Cafaro grew up in Northeast Ohio and graduated from Stanford University with a degree in American Studies. She continued her post-graduate studies at Georgetown University where she earned a master's degree in international studies. After



college, Senator Cafaro pursued a career in public service which led to an appointment to the Ohio Senate in January 2007 to represent the 32nd District covering Trumbull and Ashtabula counties. In just

over two years, she has risen through the leadership ranks, serving first as Assistant Minority Whip, and now as Minority Leader.

Senator Cafaro has served on numerous councils and committees to advocate for Medicare and improved health care for older adults on both the state and national level. She has been a member of the Trumbull County Senior Services Advisory Council and was a State Policy Liaison for Ohio with the National Patient Advocate Foundation. Senator Cafaro was also a State Advocate Representative for the National Committee to Preserve Social Security and Medicare. In addition, as a member of the State Legislature she has served on the Joint Legislative Committee on Health Care Oversight, the Medicaid Administrative Study Council and the Unified Long-Term Care Budget Work Group.

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## Ohio Health Quality Improvement Summit (OHQIS) Releases Summary Report

### Background

The Ohio Health Quality Improvement Summit (November 2008) engaged more than 180 individuals interested in aggressively pursuing health reform. Participants at the event developed a set of strategies and tactics that would optimize the health of Ohioans across the continuum of care from prevention through end of life. The summit was the result of Ohio's participation in the Commonwealth Fund/AcademyHealth State Quality Improvement Initiative (SQII) with the goal of developing strategies and tactics to transform Ohio's health care sector into a high quality, cost-effective system that will optimize the health of all Ohioans. Since the Summit, a number of participants have used this work to develop the Ohio Health Quality Improvement Plan.

The Ohio Health Quality Improvement Plan was presented to a reconvening of many of those who attended the November 2008 Summit, along with others interested in the recommendations. The goal of the April 27, 2009 event was to assess reaction and obtain feedback to the plan and the work of the Core Team in the intervening months. **The AMCNO participated in both the November 2008 Summit and the April 27th event.**

### Core Team Plan and Presentation

The core team determined transforming the health care system for Ohioans would require creating an affordable and sustainable health care financing and delivery system and that strategies would need to be implemented to move to a system that is wellness and health focused. As a result, the team decided to break down the original 12 strategies to 4 core collaborative transformational strategies (CTS) which are as follows:

- Health Information Technology;
- Patient-centered medical home;
- Payment reform and;
- Informed and activated Ohioans.

### Outlines of the Collaborative Transformational Strategies (CTS)

#### Health Information Technology (HIT)

The strategy for HIT is to develop a technology infrastructure that supports the adoption of electronic medical records and supports the medical home concept through a robust health information exchange. A non-profit

organization will be designated to achieve these goals by creating a statewide health information network; developing a center of excellence to provide health care information technology integration and education services directly to health care providers; improving electronic medical record adoption; coordinating and leveraging the outstanding higher education system; and research and development activities within the state of Ohio. The tactics to achieve this may include the creation of a public-private partnership to provide health IT services in Ohio with the intent to formalize an electronic medical record service strategy and the development of a statewide data exchange hub which could include technical and business integration and education services.

#### Patient Centered Medical Home (PCMH)

The strategy for the PCMH is to promote the use of the patient-centered medical home approach to support the delivery of comprehensive primary care for children, youth and adults – develop the informational, technological and reimbursement infrastructure needed to implement and support widespread dissemination of the PCMH approach throughout Ohio. The PCMH should provide patients with the key points outlined in the Joint Principles for the PCMH as adopted by the major specialty societies (and the AMCNO). The tactics outlined would include the creation of a PCMH task force under the newly created Health Care Coverage and Quality Council (see end of this article for more information) and the development of payment and financing strategies to support the PCMH approach with a focus on ensuring access to high quality primary care. In addition, plans and incentives would be created to expand the primary care workforce to support the PCMH approach.

#### Payment Reform

The purpose of payment reform in this plan is to transform public and private payment systems in order to improve the value of health care spending. The concept here is to adopt payment models that support PCMHs; health promotion; patient safety; efficiency of care and efficient business practices. To achieve this, the plan is to recommend payment models that support PCMHs, and recommend payment reforms through various types of health care. Other tactics included

designing financial incentives to promote e-prescribing, e-billing and electronic eligibility verification and working with the HIT group to design incentives to promote the use of e-health records. In addition, the tactics would include the development of payment policies that discourage the use of health care services that are overused, underused, or misused and that target payment policies to discourage never events.

#### Inform and Activate Patients

This strategy is meant to promote deeper involvement by patients in improving their health and their healthcare decisions. The tactics within this strategy serve two broad aims: 1) managing health care and 2) managed health, which necessitate patient and/or individual activation in the following areas: making healthy lifestyle choices, making health care coverage choices, making health care treatment choices and making end-of-life decisions. One of the tactics noted was to promote broad public access to and use of webCHAT™ Choosing Health Plans All Together, an abbreviated Internet version of the research and educational tool used by the Ohio Department of Insurance to determine what uninsured Ohioans thought a “basic” health plan must offer (see page 11 for more details on the CHAT process).

#### Measuring Success

In addition to the strategies noted above, the core team has also recommended system level outcome measures to help focus attention on the goal of creating a high-quality, cost-effective, health system. In developing the system measures, the team recommends a balanced scorecard approach, with measure in five different areas to determine success. The proposed areas are: quality; access; wellness; health spending; and satisfaction (provider and individual). Any metrics identified would be designed to ensure that geographic, racial and other disparities are addressed. All of the proposed measure are in draft form and still under development and will require additional review and input.

The draft plan also noted that the four collaborative strategies and other state level efforts are aimed at creating an infrastructure necessary to foster a transformed health system for all Ohioans. The core team determined that this transformation would be reflected in positive outcomes in five areas: improved and optimal health for all Ohioans; available and affordable access to quality care;

(Continued on page 11)

## Ohio Health Quality Improvement Summit (OHQIS) Releases Summary Report

(Continued from page 10)

more efficient delivery of health care services; sustainable health financing and economic performance; and demonstrated satisfaction among both consumers and providers of health care. Potential measures for these five areas were included in the draft plan as well.

### Next Steps

This plan is still in draft format and under review and revisions may yet be made to the plan. The AMCNO plans to continue our involvement in how this plan develops and request that our organization be represented on the various task forces that may develop to continue work on the plan. In addition, concurrent with this Plan's development, Governor Strickland has announced the establishment of the Ohio Health Care Coverage and Quality Council, which was created through Executive Order in 2009. The Council, which will include over 30 members from diverse perspectives, is charged with advising the Governor and General Assembly on improvements to health programs and policies, monitoring and evaluating

implementation of strategies for increasing access and improving quality of the health system in Ohio; and cataloging existing health care data reporting efforts. The recommendations contained in the final Ohio Health Quality Improvement Plan will be presented to the Council at its first meeting with the expectation that the Council and its members will act to implement these recommendations and/or others to transform the health care system in Ohio.

**Editor's note:** *The AMCNO physician leadership was asked to reply to the strategies and tactics contained in the plan. Our response to the Governor's office indicated that The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) could help implement any number of the strategies and tactics, however, if we were to pick one that is a priority for our organization it would be the implementation of an appropriate health information technology (HIT) infrastructure which is of utmost importance to both physicians and our patients in the future. In order to achieve the HIT goal interoperability issues and cost factors for physicians must first be addressed. With regard to the strategies and tactics outlined in the plan,*

*clearly a HIT infrastructure will be necessary in order to track patients and their records through a patient-centered medical home model, as well as to evaluate chronic diseases, patient compliance issues and follow-up care.*

*AMCNO also noted in our response that physicians are faced with inefficient health system spending that does not add any value to patient care, such as excessive costs associated with dealing with the myriad insurance companies. Real payment reform cannot be achieved without the use of HIT to provide for the electronic transfer of information between physicians and payors on a real time-basis. However, this will require changes not only on the part of physicians but uniform changes by the insurance industry as well. In addition, AMCNO noted that patients must be an integral part of the discussion since declining health status also contributes to medical costs. In addition to focusing on the HIT issue, the council should strive to engage the consumers of health care in this debate to assure that there is a cultural transformation and patients begin to take a proactive role in improving their health status. The AMCNO plans to continue to participate in discussions on the strategies and tactics as this discussion continues in the future.*

## Ohio Department of Insurance Issues CHAT Report: Uninsured Ohioans Voice Opinions on What a Basic Health Plan Must Cover

The Ohio Department of Insurance (ODI) has issued a final report detailing what uninsured Ohioans think a "basic" health plan should offer, Director Mary Jo Hudson said. Department representatives traveled statewide with the health plan computer program CHAT – Choosing Healthplans All Together. A total of 18 CHAT sessions were held in 14 counties from March through November 2008 with 177 diverse participants. The results of the CHAT show that Ohio's uninsured residents want meaningful coverage but also coverage that is cost effective. The report is available at [www.insurance.ohio.gov](http://www.insurance.ohio.gov).

The CHAT project is part of a larger effort to develop programs to cover Ohio's uninsured residents. In his Executive Budget, Governor Ted Strickland has taken initial steps to provide affordable coverage to 110,000 more Ohioans. In order to determine these adequate protections, the Department asked participants through the CHAT process to construct a health plan that is cost-effective yet offers sufficient protections for uninsured Ohioans given a tight budget.

In three-hour sessions, through individual

and collective decision-making processes, CHAT participants negotiated trade-offs across 16 categories of coverage needs (catastrophic, complex chronic care, dental/vision, end-of-life care, episodic care, maintenance, maternity, mental/behavioral, obesity, prevention, quality of life, restorative, care management, co-payments, premium, and providers) and developed a "basic" plan for all Ohioans, ages 18 through 64. Most CHAT participants agreed upon the following principles or values for a "basic" health plan:

- **Affordability:** The plan must be financially accessible to individuals at the lower to middle income levels; young adults; older adults not yet eligible for Medicare; and those diagnosed with chronic health conditions.
- **Quality:** The plan must emphasize quality care much more so than simply having more choice of providers.
- **Prevention:** Healthcare coverage should be reasonably comprehensive (i.e., acute care and preventative care) and provide for all levels of prevention.
- **Collective Good:** Ohioans would be healthier and more productive if all aspects of health, including mental/behavioral and dental/vision benefits, were coordinated and taken seriously in a basic health plan.
- **Exclude Low-Value Interventions:** The plan must include high-value and cost-efficient interventions. High-value interventions compel providers to follow established clinical guidelines for treatment and care would still be patient-centered.

(Continued on page 12)

# STATE ACTIVITIES

## Ohio Department of Insurance Issues CHAT Report

(Continued from page 11)

The Department utilized the Health Policy Institute of Ohio's 2004 Ohio Family Health Survey to determine the counties to survey.

The following factors of each county (Allen, Cuyahoga, Franklin, Hamilton, Jackson, Lucas, Mahoning, Marion, Miami, Montgomery, Muskingum, Ross, Van Wert and Wayne) were reviewed: uninsured rate; poverty rate; unemployment rate; and race/ethnicity. Participants came from a

diverse background considering age and gender; race /ethnicity; income and employment status; and geographical area.

Using the 16 categories, the CHAT participants selected the following health plan, contrasting the benefits and sacrifices:

Healthcare Need	Benefits Selected	Benefits Sacrificed
<b>Prevention</b>	Wellness treatment that meets national standards	Screenings that offer little chance of finding problems
<b>Maintenance</b>	Doctor must follow expert guidelines for least costly treatment These treatments work well for 90% of patients	Doctor can order any treatment or drug Doctor does NOT need to follow expert guidelines
<b>Complex Chronic</b>	Doctor uses least costly ways to manage illness	Covers costly treatments like knee replacement and heart transplant
<b>Episodic Care</b>	Emergencies and urgent care dealt with quickly	Can see the doctor earlier, wait is several weeks or LESS if not an emergency or urgent
<b>Catastrophic</b>	Must wait several weeks or LONGER to see a doctor if not urgent Treatments are given to save the patient's life Pays for all medical care known to be useful	Pays for treatments that have little chance of helping or may not work
<b>Restorative</b>	Covers necessary rehabilitation services to improve function	Basic equipment for daily living Covers ½ cost of costly equipment
<b>End-of-Life</b>	Hospice care in home or hospital	High tech care that postpones death
<b>Dental/Vision</b>	\$1,000 maximum dental benefit Annual vision testing with biennial glasses allowance	<b>NONE</b> , participants selected the best benefit
<b>Maternity</b>	Routine pre-natal care, normal childbirth and complications	<b>NONE</b> , participants selected the best benefit
<b>Mental/Behavioral</b>	Treatment for severe mental illness Counseling and medication for drug and alcohol addiction	Long-term counseling for less severe mental problems In-hospital drug and alcohol addiction treatment
<b>Obesity</b>	Covers, medication, counseling and if necessary stomach surgery	<b>NONE</b> , participants selected the best benefit
<b>Quality of Life</b>	<b>NONE</b> , no benefit selected	Drugs, medical and surgical treatment to correct non-disabling problems
<b>Co-Payments</b>	Mid-range co-payments of \$20/doctor visit, \$10 generic drug and \$20 brand-name drug \$100/ER visit and \$250/hospital visit	Lowest co-payments of \$10/doctor visit, \$5 generic drug and \$15 brand-name drug \$25/ER visit and \$100/in-patient hospital visit
<b>Premium</b>	Mid-range health premium of 4% of salary (\$66/mo for \$20,000/yr salary)	Lowest health premium of 2% of salary (\$33/mo for \$20,000/yr salary)
<b>Providers</b>	Limited choice of doctors and hospitals Referrals needed for specialists	Extensive choice of doctors and hospitals Referrals not needed for specialists
<b>Care Management</b>	Health review forms and care management classes are required	Patient choice to participate in health Review forms and care management classes

CHAT is a proprietary and educational research tool developed by the University of Michigan and The National Institutes of Health with support from the Robert Wood Johnson Foundation. This computer-based program examines consumer healthcare choices in the context of limited resources. The software has been used in the United States and overseas.

For more information about the Governor's health care coverage reform initiative, visit [www.healthcarereform.ohio.gov](http://www.healthcarereform.ohio.gov).

**Editor's Note:** As part of the Cover the Uninsured Week initiative, The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) sponsored two of the Ohio CHATs About Healthcare sessions in May 2008.

The AMCNO was pleased to participate in the CHAT project, and our name was disseminated statewide by the Ohio Department of Insurance (ODI) in a news release regarding the project and the partners involved in the event. The ODI has expressed appreciation to the AMCNO in the final report for our involvement in the project and the AMCNO will continue to work with ODI on the issue of healthcare coverage reform in the state of Ohio.

## 8th Annual Immunization Symposium

The Consortium for Healthy & Immunized Communities, Inc. (CHIC) will be hosting the 8th Annual Immunization Symposium on September 25, 2009 at Windows on the River in Cleveland. This is a one-day, category 1 CME event from 8-4 p.m. with breakfast, lunch and free parking. CHIC has consistently brought current immunization education, issues and trends to physician providers, nurses and legislators through nationally recognized speakers. The Academy of Medicine of Cleveland Foundation (AMEF) has contributed to the support of this year's conference which promises to be an outstanding event. Also sponsoring the event are the Ohio Department of Health, Every

Child by Two, and Wright State's Boonshoft Medical School.

Keynote speaker, Dr. Lance Rodewald, Director of Immunization Services Division, and Jane Seward, MBBS, MPH, Deputy Director, are both from the National Center for Immunizations and Respiratory Diseases, Centers for Disease Control and Prevention. In addition, Dr. Ari Brown, pediatrician and author of the best selling book *Baby 411* will be joined by Dr. Sylviana Ng, internal medicine, Cincinnati, Ohio; and Frankie Milley, Founder and Director of Meningitis Angels. For more information or to receive an invitation, email: [cmodie@ccbh.net](mailto:cmodie@ccbh.net).

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## U.S. Supreme Court Issues Landmark Decision Regarding Pharmaceutical Warnings

Edward E. Taber, Esq.  
Jeffrey M. Whitesell, Esq.

March 4, 2009 marked a dramatic day in medical litigation across the country. On this day, the United States Supreme Court issued its long awaited decision in the watershed case of *Wyeth v. Levine*. In *Wyeth*, the Court held that the manufacturer of a prescription drug could still be sued in state court for alleged defects in the drug's warning label, *even though* that warning label was fully approved by the United States Food and Drug Administration ("FDA"). The legal term of art defining this high-stakes battle is "FDA preemption."

Prior to *Wyeth*, many pharmaceutical and medical device manufacturers argued that so-called "failure to warn" lawsuits should be dismissed because the FDA exclusively governed warning label content – not personal injury lawsuits where lay jurors serve as the arbiter. Hence, such lawsuits were "preempted" by the actions of the FDA. Many such "failure to warn" lawsuits around the country were either dismissed or on hold based on FDA preemption defenses, prior to release of the *Wyeth* decision on March 4th. Now that *Wyeth* has been decided, many lawsuits against pharmaceutical manufacturers will be given new life. Physicians or other health care providers are often sued as co-defendants in such lawsuits, as was the case in *Wyeth*.

Factually, the plaintiff in the *Wyeth* case, Diana Levine, underwent a right forearm amputation following intravenous push administration of Phenergan and subsequent gangrene. The Phenergan either extravasated, or was improperly injected into the patient's artery. Ms. Levine sued the health care clinic and its staff, and the manufacturer of the Phenergan (Wyeth). Ms. Levine settled her claims against the health care clinic and its staff, and proceeded to trial against Wyeth – leading to a \$7.4 million jury verdict in her favor in Vermont state court. This verdict was then appealed by Wyeth through several levels of appellate courts, leading ultimately to the March 4th U.S. Supreme Court decision. The majority decision was issued by Justices Stevens, Kennedy, Souter, Ginsburg, Breyer and Thomas. Justices Alito, Roberts and Scalia dissented.

Edward Taber and Jeffrey Whitesell are attorneys with the Cleveland office of Tucker Ellis & West LLP, practicing in the Medical and Pharmaceutical Group. They can be reached at (216) 696-2365 or via the web at [www.tuckerellis.com](http://www.tuckerellis.com).

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For information contact:

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## Greetings from the President

It is indeed a privilege to serve as President of the Academy of Medicine of Cleveland and Northern Ohio (AMCNO). The AMCNO serves its physician members at the professional level. What exactly does this mean? There are specialty societies that meet the needs of a physician with regard to their specialty. There are medical staff organizations that address the relationship of a physician with his or her respective hospitals. And, there are professional societies, like the AMCNO, that deal with the aspects of medical practice in a more global sense. Our primary concern is to promote the best possible quality of medical care by physicians in our region. It is also to be advocates for the patients whom we serve. For physicians, this transcends specialties, employment models and hospital affiliations. For patients, this transcends location, financial status and the need for access.

The AMCNO represents more than 5,000 physicians in Northern Ohio in all specialties, and in all types of practice structures. Our focus is and will continue to be representing those interests of our physician members that will allow them to practice quality medicine in our area. This includes maintaining an awareness of the needs of society as evidenced by both government and the public interest. The AMCNO follows the activities of local, state and national legislative bodies as their activities relate to medical practice. We also provide information to legislators to enable them to propose legislation that facilitates better access to medical care and optimal quality of the care which we deliver.

Besides the interaction with government, the AMCNO responds to local needs of our patients. The special needs of children, the elderly and the uninsured are important to physicians. We provide advice and education wherever possible to enhance care to those whom we, as physicians, provide service.

I ask our members to become involved. There are many ways in which physician members can become involved in the AMCNO. The committees, along with the executive staff, do the "work" of the AMCNO. There are many opportunities to bring expertise and ideas to move our mission forward. In addition, there are opportunities for volunteerism which only succeed when members become involved. For example, the Academy's Mini-Internship program (see below) held every fall depends on member's participation for its success. Finally, the Academy needs the support of its fund raising activities, such as the Annual Golf Outing which supports the Educational and Research Foundation.

Like any organization, the AMCNO is only as good as its membership. By participation and involvement, our member physicians give back to the profession. In so doing, we give back to the patients which we serve and to the society in which we work.



Anthony E. Bacevice, Jr., M.D.  
2009-2010 President, AMCNO

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## The AMCNO's 25th Annual Mini-internship Program

October 20 & October 21, 2009

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Highlights of 2008-09 AMCNO Working on Behalf of Our Members and their Patients

**LEGISLATIVE ACTIVITIES**

- Spearheaded the introduction of legislation in Ohio that would address the issue of physician ranking by insurance companies.
- Met with the legislative committee of the State Medical Board of Ohio, the Ohio Department of Insurance and the Ohio Attorney General to obtain their input and level of support for the AMCNO sponsored physician ranking legislation.
- Continued our work on the issue of resolving medical liability cases through alternative dispute resolution concepts such as mandatory arbitration pilot or the development of special medical courts.
- Advocated for and supported the passage of HB 125 – the Healthcare Simplification Act, legislation that passed in the Ohio legislature requiring health plans to be much clearer and open about contract terms with physicians, including disclosing what insurers will pay for services.
- Facilitated meetings with federal legislators regarding Medicare reimbursement issues, as well as state and local judges and legislative leaders to continue strong working relationships for the AMCNO.
- Developed Meet and Greet opportunities for physician members during the Ohio Supreme Court election campaign.
- Supported and helped achieve a reversal of the 2008 Medicare payment cuts – while continuing to advocate for a change to the Sustainable Growth Rate (SGR) formula used to calculate physician fees.
- Created and disseminated a Voting Guide for our members – inclusive of information on Common Pleas judges running in Northern Ohio Counties.
- Reviewed and took positions on over 100 healthcare related bills under review at the State legislature making our position known to bill sponsors and committee chairman – inclusive of written testimony - enhancing the AMCNO presence at the Statehouse.
- Continued our legislative lunch concept – an opportunity for physicians at area hospitals to meet and greet legislators from their district.
- Participated in the Ohio Department of Insurance (ODI) Commission on Most Favored Nation Clauses in Healthcare Contracts committee discussion.
- Supported the passage of legislation that allows the State Medical Board of Ohio to track information through physician licensure applications that will be useful in tracking specialty-specific data, as well as physician supply and demand issues and medical student enrollment needs.

- Worked with Cuyahoga County representatives and other stakeholders on the Access to a Medical Home Initiative to collaboratively address the issue of care of the uninsured, underinsured and Medicaid populations in Northern Ohio.
- Continued as a participant in the Northeastern Ohio Regional Health Information Organization (NEORHIO).

**PUBLIC RELATIONS**

- Conducted myriad exclusive interviews on the Healthlines radio program with physician members of the AMCNO.
- Provided detailed spotlight articles about area legislators in the Northern Ohio Physician magazine.
- Entered the 49th year of operation for the AMCNO Pollen Line – currently run and maintained by longstanding AMCNO members, Drs. Robert W. Hostoffer, D.O., Theodore H. Sher, M.D. and Haig Tcheurekdjian, M.D. of Allergy/Immunology Associates Inc.
- Published numerous scientific and medical articles written by AMCNO members in the Northern Ohio Physician.
- Provided physician presenters through our Speakers Bureau to present on medically related topics to community organizations and schools.

**Benefits of Membership  
in the AMCNO**

Renowned Physician Referral Service  
 Representation at the Statehouse  
 through McDonald Hopkins, Co. LPA  
 Specialty Listing in *Member Directory  
& Community Resource Guide*  
 Practice Promotion via  
*Healthlines* radio program  
 Reimbursement Ombudsman  
 CME Seminars  
 Peer Review  
 Speaker's Bureau opportunities  
 Insurance/Financial Services  
 Weekly, quarterly and bimonthly  
 publications offering healthcare news  
 and practice guidance  
 Member Discounts including Worker's  
 Comp, Practice Management Classes  
 at Tri-C and so much more!

**SCHOLARSHIPS**

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

**PHYSICIAN EDUCATION OPPORTUNITIES**

- Hosted topical sessions addressing medical legal issues such as current trends in malpractice allegations and risk management, practice pitfalls – HIPAA compliance and informed consent issues, electronic health records/technology and never event issues.
- Provided a forum for resident members outlining how young physicians should prepare for the business aspects of practicing medicine.
- Partnered with Tri-C to offer discounted practice management classes to physicians and practice managers.
- Provided timely information to our members on issues of importance to their practice such as the new IRS 990 form, contracting for electronic health records, medical licensure issues and much more.
- Through our Medical Legal Liaison Committee provided timely advice on how to be proactive when faced with medical liability cases.

**PRACTICE MANAGEMENT**

- Met with the Ohio Department of Insurance regarding prompt pay and external review issues.
- Provided timely information to our members on managed care issues and the yearly update on the fees to be charged for transfer of medical records.
- Participated in regional sessions conducted by the Ohio Department of Job and Family Services (ODJFS) on the Ohio Medicaid Managed Care Program.
- Continued our active participation as a member of the UnitedHealthCare Physician Advisory Board voicing our concerns on various issues impacting physicians and their practice.
- Disseminated timely and topical news to practice managers through our publication Practice Management Matters.
- Provided our members with services designed to resolve insurance company disputes with third party payers in Northern Ohio.
- Provided a third party payor seminar for practice managers and physicians – an event created by the AMCNO now entering its twenty-seventh year.
- Provided members with detailed information on the Red Flag Rules inclusive of sample forms for usage in the physician's office to achieve compliance with the rules.

**COMMUNITY EFFORTS**

- Conducted our ninth annual successful Vote and Vaccinate event on Election Day offering flu and pneumonia vaccines through our community partnerships in underserved areas.
- Hosted the 24th annual Mini-internship program that allows community members to shadow AMCNO physicians in their practice setting.
- Continued our active support of the Steps to a Healthier Cleveland initiative.
- Sponsored two Choosing Health Plans All Together (CHAT) sessions examining health care coverage needs as part of the Cover the Uninsured Week in cooperation with the Ohio Department of Insurance.
- Joined the Partnership to Fight Chronic Disease – a national effort committed to improving health care policies through more effective prevention and management of chronic disease.
- Worked with the Ohio Department of Insurance (ODI) to develop a toolkit for patients and physicians on how to appeal a health coverage claim and how to file an external review request.
- Continued as an active participant in the Aligning Force for Quality Initiative in Northern Ohio (Better Health Greater Cleveland), a multi-stakeholder alliance committed to improving the quality of care for people with common chronic conditions.

**BOARD INITIATIVES/ADVOCACY**

- Agreed to become an active participant in the Ohio Department of Insurance (ODI) HB 125 Real Time Adjudication and Claims Eligibility review process – providing comments on the final recommendations sent to the Ohio General Assembly for legislative action.
- Continued to garner support from area physician groups to increase the AMCNO membership numbers to over 5,000 physicians from across the Northern Ohio region.
- Spearheaded the introduction of legislation in Ohio to address the issue of physician ranking/designation systems utilized by health insurers.
- Agreed to support RAM Ohio in principle and assist in recruiting physicians for the event if professional liability and follow-up care issues were addressed; and agreed to provide detailed information to our membership regarding what is covered under Ohio's charitable immunity law.
- Agreed to participate in the Ohio Health Quality Improvement Summit (OHQIS) convened by Governor Strickland with the intent to identify strategies to transform Ohio's health care system into a high quality, cost-effective, high performing system that optimizes the health of Ohioans.
- Strongly supported statewide efforts to increase the tax on other tobacco products such as smokeless tobacco and small cigars as a member of the Investing in Tobacco Free Youth Coalition.
- Developed a detailed response to the Centers for Medicare and Medicaid Services (CMS) stressing the need to change the state of Ohio calculations for the Geographic Practice Cost Indices (GPCIs) to provide for fairer reimbursement levels for Northern Ohio physicians and expressed our support for changing the state of Ohio to fifteen payment localities in order to address geographic differences.
- Approved and developed a charity care survey for the AMCNO membership.
- Realigned the Academy of Medicine Education Foundation (AMEF) and revised the foundation code of regulations and articles of incorporation to develop a better working relationship with the AMCNO.
- Sent a specific written request to Chief Justice Moyer of the Ohio Supreme Court requesting the usage of specially trained judges for special courts or as a resource in medical liability issues.
- Adopted the Joint Principles of the Patient-Centered Medical Home – including guidelines for the coordination of care to improve the patient-physician relationship, quality and safety, access to care, and the payment model for coordinated services.
- Voiced concerns to UnitedHealthCare regarding their potential usage of an after hour telephonic consultation process for UHC subscribers.

**Is YOUR Voice Being Heard?**

**Already an AMCNO member?** Now is the time to renew your commitment to organized medicine that makes a real difference in your practice and our region. Look for a 2010 dues billing in your mail soon!

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

# AMCNO ANNUAL MEETING

The Academy of Medicine of Cleveland & Northern Ohio held its Annual Meeting Dinner and Awards Presentation on Friday, April 24 at the Ritz Carlton in downtown Cleveland. One of the meeting highlights was the awarding of six medical student scholarships by the Academy of Medicine Education Foundation to local medical students.

The 2009 list of honorees was led by **Jeffrey L. Ponsky, M.D.**, receiving the John H. Budd M.D. Distinguished Membership Award for his exemplary contributions in the local healthcare community over the course of his career. **Delos M. Cosgrove III, M.D.**, was honored with the Charles L. Hudson Distinguished Service Award in recognition of his leadership and myriad contributions to organized medicine in the northern Ohio community. The 2009 Clinician of the Year designation went to **Kevin T. Geraci, M.D.**, recognizing his superb accomplishments in active practice and research.

**Michael T. Gyves, M.D.**, received the Academy's Special Honors Award for his longtime service to the medical profession and the community. The Honorary Membership Award was received by **Brian F. Keaton, M.D.**, for his leadership, work and collaboration with the AMCNO and community on health information technology issues.

The Academy presented the **Honorable George V. Voinovich** with a Special Recognition Award for his dedicated work and outstanding contributions to the community in the field of health care in the legislature. And an AMCNO Presidential Citation Award was given to **George H. Allen, Jr.** posthumously for his longstanding service to the AMCNO. Each award recipient was afforded an opportunity to thank the AMCNO for the award.

The Academy of Medicine Education Foundation (AMEF) presented six local medical students with scholarships worth \$5,000 each at this year's AMCNO Annual Meeting. The scholarships were awarded to **Patrick Blake**, Cleveland Clinic Lerner College



*Dr. Scheetz delivers his outgoing address to the annual meeting audience.*



*The 2009 50 year awardees that attended the reception gather for a group photo prior to the start of the meeting.*



*The AMCNO past presidents in attendance for the evening shared a moment together prior to the festivities. Left to right – Dr. James Taylor, Dr. Wilma Bergfeld, Dr. Kevin Geraci, Dr. George Kikano, Dr. Paul Janicki, Dr. Ronald Savrin, Dr. John Bastulli, Dr. Hermann Menges, Jr., and Dr. Victor Bello.*



*The 2009 annual meeting honorees or their representatives pose for a picture prior to the meeting. Left to right – Mr. Zachary Ponsky, Dr. Brian Keaton, The Honorable George Voinovich, George Allen, III, Mrs. George Allen, Dr. Kevin Geraci, Dr. Michael Gyves and Dr. Delos Cosgrove III.*

of Medicine; **Edwin Jackson**, Ohio University School of Medicine; **Priya Malik**, Cleveland Clinic Lerner College of Medicine; **Marisa Quattrone**, Case Western Reserve University School of Medicine; **Syed Mahmood**, Case Western Reserve University School of Medicine; and **Rachel Roth**, Cleveland Clinic Lerner College of Medicine.

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

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

Following the awards ceremonies, outgoing president Raymond J. Scheetz, Jr., M.D.,



*The AMEF scholarship recipients gather at the podium after receiving their \$5,000 scholarship award. Left to right – Patrick Blake, Edwin Jackson, Priya Malik, and Marisa Quattrone.*

passed the AMCNO gavel for the 2009-2010 year to Anthony E. Bacevice, Jr., M.D. who commented during his acceptance speech how important it is for members to become involved and participate in the AMCNO in some way (see President's Greeting on page 16).

# AMCNO ANNUAL MEETING





**THE STRENGTH TO HEAL**  
*and stand by those who  
stand up for me.*

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