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AMCNO Co-Sponsors Electronic Health Records Training Sessions

In October, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to co-sponsor two electronic health record (EHR) training sessions for physicians and their practice staff. Other co-sponsors included the Ohio Health Information Partnership (OHIP) and the Case Western Reserve University Regional Extension Center (CWRU REC). One session was held at the EMH Regional Medical Center and another session took place at the AMCNO offices. AMCNO Immediate Past President **Dr. Anthony E. Bacevice, Jr.**, participated at EMH and AMCNO President-Elect **Dr. Lawrence T. Kent** participated at the AMCNO event.

Both sessions provided detailed information to physicians, practice managers and information officers on the services that are available to help them select, adopt, and meaningfully use an electronic health record (EHR). The sessions were planned in order to provide physicians and their practices located in the CWRU REC region with information on how they could qualify for subsidized technical support and assistance for EHR selection and implementation. The presenters also covered what a practice would need to do in order to achieve meaningful use (MU) of their EHR, and if the MU guidelines are met how much incentive money a practice could receive – and when.

*AMCNO President-Elect **Dr. Lawrence Kent** provides the opening remarks for the session at the AMCNO offices.*

AMCNO leadership noted that recent studies have shown that the adoption of EHRs by physicians is relatively low, in many

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HITECH Act: *The Good, The Bad and What You Must Know Now*

By David Valent, Esq. – Reminger Co., L.P.A.

Introduction

President Obama signed into law the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") on February 17, 2009. The HITECH Act modifies the existing Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, governs privacy and security concerns associated with the use of Electronic Health Records (EHR), and provides incentives for healthcare providers to implement EHR systems. Numerous provisions of the HITECH Act are now already active law, while several additional provisions will begin taking effect in 2011 and beyond. The primary purpose of this article is to inform you of the most relevant provisions applicable today (the good and the bad), and also to shed some light on the future implications of the HITECH Act.

In light of the HITECH Act, the Congressional Budget Office estimates that 90% of all physicians will be operating on an EHR system by 2019.

The Good

The HITECH Act provides tremendous incentives to hospitals and healthcare professionals to encourage the adoption of EHR systems. The federal government, through the HITECH Act, will make money available to qualifying providers who switch to EHR systems. Beginning in 2011, money is available to providers treating Medicare and Medicaid patients. Eligible providers will be entitled to receive incentive payments each year through 2016, for a total amount

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AMCNO Co-Sponsors Electronic Health Records Training Sessions

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cases due to the cost of installation and implementation. To address this issue, the governments at both the state and federal levels have made the adoption and transitioning to an EHR a major priority which will result in a complete change in how physicians and patients view a medical record. This change will include how physicians input information into a medical record and how they use that record for the purpose of reimbursement and exchange of information among other practices. While this change may not come easily to some practices, the federal government has made a financial commitment to try to help practices with this transition by making unparalleled investments in health information technology.

***Dr. Anthony E. Bacevice, Jr**., AMCNO Immediate Past President discusses EHR implementation at the Elyria session.*

Ms. Cathy Costello from OHIP responds to a question from the audience.

Ms. Cathy Costello, JD, OHIP's Project Manager for REC services provided a detailed overview of OHIP noting that OHIP was established to serve two functions in Ohio: 1) develop a statewide health information exchange for Ohio to allow hospitals and physicians to communicate electronically and 2) coordinate the regional extension centers (RECs) to assist with the adoption of health information technology by physicians in Ohio. The RECs are charged with providing assistance in the areas of workflow assessment, selection and purchase of an EHR system; and in conjunction with vendors, going live on an EHR system and assuring that the practice attains meaningful use with the system. She explained that REC grant funding flows from OHIP to the REC for providing education and assistance in EHR adoption – it does not include the stimulus dollars for physicians and others who purchase and implement an EHR system in a meaningful way. Although the REC can provide services to all physicians, only priority primary care providers or PPCPs (physicians practicing in a primary care area, defined as internal medicine, family practice, pediatrics or obstetrics/gynecology) can receive subsidized services provided by the REC.

With regard to the EHR incentive program, Ms. Costello explained that if you are an eligible professional and you treat either Medicare or Medicaid patients, then you may be eligible for incentive payments if you adopt an EHR system and use it in a meaningful manner. With regard to choosing an EHR for their practice, Ms. Costello stressed that the first step for physicians should be to perform a business analysis noting that it is important to approach this as a business decision for the practice. Finally, she provided information on the differences in the Medicare/Medicaid incentive programs and how to attain meaningful use.

Mr. Joe Peter, CWRU REC Director, explained that the REC services will include practice and workflow assessment, guidance in the EHR vendor selection process, review of contract deliverables, monitoring of the vendor implementation plan; assistance with the practice going live with an EHR and providing a meaningful use assessment. Select consultants will guide physicians through the identified critical steps to implement EHR. Mr. Peter summarized what the REC can do for a practice noting that it is an opportunity to utilize experienced consultants who have had past success in implementing an EHR, and utilize consulting services at low or no cost.

(For more information on meaningful use criteria, incentive payments and OHIP see the September/October issue of the *Northern Ohio Physician* magazine or go to www.ohiponline.org. Physicians interested in learning how to sign up for REC services may also contact the AMCNO at 216-520-1000 or Mr. Joe Peter at 216-368-5756).

HITECH Act: *The Good, The Bad And What You Must Know Now* *(Continued from page 1)*

up to $44,000 from Medicare, and $65,000 from Medicaid, per individual provider adopting an EHR method of record keeping. With that said, it is important to note that there are particular requirements that must be met under the HITECH Act, before the incentive money is made available.

The Bad

From a healthcare provider's perspective, the "Bad" results when the provisions of the HITECH Act are not followed. Pursuant to the HITECH Act, the penalties for violating/breaching HIPAA privacy requirements have increased greatly. Prior to the HITECH Act, a civil penalty for a violation of HIPAA would vary, but never exceed $25,000. Under the HITECH Act, the maximum threshold for civil penalties has increased to $1.5 million per violation, per year. Also, violators of the HITECH Act are subject to criminal penalties in addition to the aforementioned civil penalties.

Pursuant to the HITECH Act, penalties for violating HIPAA are currently tiered as follows:

- If the individual did not know, through the exercise of reasonable diligence, that he/she violated the statute, the individual is subject to a penalty of: $100 to $50,000 per violation, but not more than $1.5M per type of violation per calendar year.
- If the violation was due to reasonable cause and not willful neglect, the individual is subject to a penalty of: $1,000 to $50,000 per violation, but not more than $1.5M per type of violation per calendar year.
- If the violation was due to willful neglect, but was corrected within 30 days per HIPAA requirements, the individual is subject to a penalty of: $10,000 to $50,000 per violation, but not more than $1.5M per type of violation per calendar year.
- If the violation was due to willful neglect, but was not corrected per HIPAA requirements, the individual is subject to a penalty of: at least $50,000 per violation, but not more than $1.5M per type of violation per calendar year.

Also, the HITECH Act requires the U.S. Department of Health & Human Services to investigate a complaint of willful neglect, and if the complaint is substantiated, to impose a mandatory statutory penalty of at least $10,000 to $50,000 per violation. Additionally, beginning in February 2012, patients may receive a percentage of the penalties accessed. The HITECH Act will, therefore, give individuals who are harmed by HIPAA violations a percentage of any civil monetary penalty or settlement reached as a result of a violation. This incentive will naturally encourage more patients to identify and assert alleged HIPAA violations against their providers.

The HITECH Act also extends liability to "business associates" of healthcare providers, a provision that did not otherwise exist under HIPAA. Business associates must now comply with HIPAA privacy rules, even if those duties are not included in their business associate contracts. If a business associate violates an applicable privacy regulation, the business associate may be liable for civil and criminal penalties pursuant to the HITECH Act. Most software vendors providing EHR systems are qualifying as business associates.

What is more, while it has been mentioned that incentives are available to those providers who switch to EHR systems, it is conversely true that there are penalties for those providers who fail to switch to an EHR system. If an eligible medical professional fails to become a "meaningful user" of an EHR system by 2015, Medicare payments made to providers will be reduced beginning at a rate of 1% in 2015, increasing to an eventual rate of a 3% reduction in later years. Currently, there are no disincentives or penalties in place as it relates to Medicaid claims.

Why is the HITECH Act Needed?

Congress performed extensive research, concluding that utilizing EHR would improve patient care, increase patient safety and simplify compliance in the healthcare system. For these reasons, Congress has gone out of its way to encourage the implementation of EHR systems, through the passing of the HITECH Act. The HITECH Act is intended to cut healthcare costs in the long run, minimize errors and increase productivity and efficiency.

What is the Key Modification to HIPAA Under The HITECH Act?

HIPAA did not require covered entities (i.e., healthcare providers) to notify patients of improper disclosures of protected health information (PHI). However, pursuant to the HITECH Act, covered entities are required to notify affected individuals of security breaches.

What Constitutes a Breach Under the HITECH Act?

A breach is defined as "the unauthorized acquisition, access, use, or disclosure of protected health information which comprises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information." (HITECH Act at §13400(1)(A)). Protected health information is defined as "individually identifiable information" that is "unsecured." (HIPAA Privacy Rule at 45 C.F.R. §160.103).

To What Extent is Notification of a Breach Required?

Timing and notice of the breach must be given "without unreasonable delay," and in no event later than 60 days after the date of the discovery of the breach (HITECH Act at §13402(D)). In general, a covered entity that discloses unsecured PHI must notify each individual whose PHI has been disclosed as a result of such breach. The content of the notice should include: (i) a brief description of what happened, including the date of the breach and the date it was discovered; (ii) a description of the type of unsecured PHI disclosed; (iii) a brief description of what the covered entity is doing to investigate the breach, mitigate loss and protect against further breaches; (iv) the steps the individual should take to protect themselves; and (v) contact procedures for individuals with follow-up questions. Methods of notice include individual notice by way of written notification, first class mail, or in certain instances, a conspicuous posting by the government on the home page website of the covered entity, or in major print or media broadcast in the area where the affected individuals reside. Media notice shall be provided when unsecured PHI of 500 or more individuals has been disclosed. Notice to the Department of Health and Human Services is also necessary when such breach occurs.

Additionally, pursuant to the HITECH Act, a business associate of a covered entity that discloses PHI shall, following the discovery of the breach, notify the healthcare provider of such breach.

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Have You Signed Up For OARRS?

The Ohio Board of Pharmacy manages OARRS, the Ohio Automated R_X Reporting System, a program for prescribers to obtain patient-specific prescription information to use when treating a patient. OARRS is a program that collects prescription data from pharmacies licensed by the Ohio Board of Pharmacy. Information is stored in a high security database. The report should be used to supplement a patient evaluation, to confirm a patient's drug history, or to document compliance with a therapeutic regimen.

The OARRS database includes dispensing information regarding Schedules II – V controlled substances, carisoprodol products (e.g., Soma) and tramadol products (e.g., Utram). The OARRS report is based on data entered by the dispensing pharmacy. It takes up to 10 days from the date the prescription is dispensed until it appears in an OARRS report. The OARRS website is available 24/7 and most reports may be viewed within 15 seconds after the request is submitted.

OARRS is a free online tool for physicians and other prescribers to check to see if new or existing patients are potentially abusing dangerous drugs or obtaining prescriptions from multiple providers that could cause adverse drug interactions. Outpatient pharmacies that dispense controlled substances to Ohio residents are required to report information into the database at regular intervals. Any prescriber can access OARRS to obtain detail prescription drug histories that include the:

- Patient's name, address and phone number
- Patient's date of birth and gender
- Quantity of drug
- Days supply of drug
- Date of dispensing
- Date of prescription written or authorized
- Number of refills authorized
- Prescriber's DEA registration number
- Pharmacy's name and contact information

The AMCNO supports voluntary use of OARRS and urges its members to register and query the system when appropriate. To establish an account with OARRS:

- Go to http://www.ohiop;mp.gov and complete the online registration
- Print the application and have your signature notarized
- Mail the application and a copy of your driver's license, medical license and DEA registration to the Ohio State Board of Pharmacy
- The registration process takes about two weeks.

Contact the OARRS program staff at the Ohio Board of Pharmacy by email at: info@ohiopmp.gov or by phone at (614) 466-4143. ■

HITECH Act: *The Good, The Bad And What You Must Know Now*

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What Obligations Does the HITECH Act Place on Business Associates?

The HITECH Act enforces its privacy regulations against "business associates," a provision that did not otherwise exist under HIPAA (HITECH Act §13401 and §13404). Business associates must comply with HIPAA security rules that require specific administrative, technical and physical safeguards to protect electronic protected health information. If a business associate violates an applicable privacy regulation, the business associate may be liable for civil and criminal penalties pursuant to the HITECH Act.

What Should I Do Now: In Light of the HITECH Act?

As mentioned above, if you are considering switching to an EHR system, consider the switch now. The incentive money available is higher depending on how soon you make the switch. Moreover, there are penalties if you fail to switch prior to 2015. When you do indeed decide to implement an EHR system, be sure to choose an EHR vendor that is right for you. Choose a vendor that is reputable, certified, and that will meet the needs of your particular practice.

Also, take time to identify those entities you already work with who might be classified as "business associates." Update your business associate contracts to comply with the HITECH Act requirements. Furthermore, include in those contracts an indemnification provision that allows you to seek contractual reimbursement for any civil penalties resulting from a breach by the business associate.

What Other Privacy Laws Should I Follow?

Remember that in addition to the HITECH Act and HIPAA, Ohio has its own rules that help ensure the privacy of PHI. Ohio Revised Code Section 2317.02, is Ohio's law governing the protection of medical records and PHI. Whenever assessing a privacy issue, be sure to consider not only the federal regulations, but also state rules as well.

Where Can I Learn More?

The above is not intended as legal advice. Should you have any questions regarding the HITECH Act and/or HIPAA requirements, please do not hesitate to contact your Healthcare Law lawyers at Reminger Co. L.P.A. (www.reminger.com). You may contact the author of this article, David Valent, directly at dvalent@reminger.com or (216) 430-2196. You may also access much of the information discussed herein by logging on to: http://www.hhs.gov/ocr/privacy/. ■

NORTHERN OHIO PHYSICIAN

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AMCNO Legislative Update

By Mike Caputo, AMCNO Lobbyist and AMCNO staff

Update on Physician Ranking Legislation

With the end of 2010 fast approaching, the AMCNO continues to lobby for the physician ranking legislation. This lobbying includes meeting with interested parties and crafting new language to attempt to bridge the different positions of the parties.

As we have stated in prior updates, the purpose of this legislation is to provide the patient with accurate information when selecting a physician. The Bills would prevent health insurance companies from ranking physicians based solely on specific criteria such as cost efficiency.

The AMCNO worked with Representative Boyd and Senator Patton to introduce legislation in both the Ohio House and Ohio Senate. HB 122, sponsored by Representative Boyd was introduced April 2, 2009 and passed the full House on February 3, 2010 by a vote of 97 – 1. Before passage, a Substitute Bill was negotiated by the AMCNO that included changes to give the Ohio Department of Insurance (ODI) rulemaking authority, extend timelines and appeals, extend the scope of the bill to third party administrators, and have the ODI approve the appointment of the independent ratings examiner.

Senator Patton introduced the Senate version of the Bill on April 7, 2009. Both Bills are now pending in the Senate Insurance Committee that is chaired by Senator Buehrer. The process in the Senate has been slowed due to the active opposition of the Ohio Association of Health Plans ("OAHP").

To date, the AMCNO has been negotiating with the Senate on changes to our legislation that improve on the status quo without overly compromising on the core principles of the legislation. The negotiations have culminated in a new substitute version of SB 98. The substitute Bill requires any ranking system to be operated in accordance with the most current version of the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs* (the "Patient Charter"). The Patient Charter is supported by leading consumer, labor and employer organizations who share the conviction that public reporting of physician performance is integral to improving the health and health care of Americans.

These organizations believe that health plans that evaluate, rate and report physician performance to consumers should be independently assessed. The review of such programs, coupled with full public disclosure of performance results will (a) promote the consistency, efficiency and fairness of these programs, and (b) make physician performance information more accessible and easier for consumers to understand. The Patient Charter is designed to encourage better performance reporting. The substitute bill also requires the insurer to appoint and pay for an independent ratings examiner (approved by the ODI) to insure that any ratings system is in compliance with the Patient Charter.

While the Bill no longer contains a brand new cause of action for violations of the law, it does preserve all of the existing private rights of action. The Bill also states that a series of violations of these new provisions will constitute a violation of Ohio's deceptive trade practice statute.

There is still time in this General Assembly to pass this legislation. Senator Patton and Representative Boyd have both been extremely supportive. Currently, Senator Patton has expressed a willingness to allow HB 122 to move forward instead of his bill in order to increase the possibility of passage in 2010. The AMCNO will be working hard over the next 30 days to try to position the legislation for consideration. The language is close to final and the focus is now on the committee and full House process. The legislators will be returning to Columbus after the November elections and will stay into mid-December. That is the available window to move these Bills. If legislation is not completed by December, it will have to be re-introduced next year and pass through the full legislative process.

1. Ohio Prescription Drug Abuse Task Force (OPDATF) Issues Final Report

Recently, The Ohio Prescription Drug Abuse Task Force (OPDATF) issued 20 recommendations in an effort to stop Ohio's prescription drug abuse epidemic. The OPDATF developed the 20 recommendations based on the work product of four public work groups: Law Enforcement, Regulatory, Treatment and Public Health. A summary of the committee recommendations is below. For a full copy of the report, go to http://www.odh.ohio.gov/features/odhfeatures/drugod/drugoverdose.aspx.

Regulatory

- Examine the regulation of prescriber dispensing of controlled substances
- Enable state agencies and private enterprises to create medication lock-in programs
- Reduce regulatory barriers to increase utilization of evidence-based treatment practices
- Encourage increased initial and continuing education on pain management and drug abuse
- Redesign the Medicaid lock-in program
- Implement changes to the state prescription monitoring program

Treatment

- Enhance resources available within the alcohol and other drug addiction system of care for direct client services
- Adopt a statewide standardized screening and referral tool
- Increase education of prevention, intervention, treatment, and recovery support services for prescription drug abuse
- Increase utilization of evidence-based practices to meet the growing need of opioid addicted individuals seeking help
- Identify best practices for managing acute and chronic non-malignant pain, and disseminate and promote these proven approaches.

Law Enforcement

- Implement standards for pain management clinics
- Legislative reform to increase the effectiveness of law enforcement in investigating and prosecuting prescription drug abuse cases
- Promote cooperation, communication, education and training among law enforcement agencies
- Conduct comprehensive review of funding initiatives for law enforcement issues related to prescription drug abuse

Public Health

- Establish new and support existing local coalitions/task forces to address the prevention of prescription drug misuse, abuse and overdose

- Implement social marketing campaigns to create awareness about prescription drug abuse
- Provide population-specific education to increase awareness, knowledge and resources related to the risks of prescription drug abuse
- Facilitate the proper disposal of prescription medications
- Improve and coordinate data collection related to prescription drug misuse, abuse and overdose

Legislation has already been introduced in the 128th General Assembly to address the issue of pain clinics — and this bill is supported by the AMCNO. It is unlikely to pass before the end of this year, however, and it will probably have to be re-introduced next year. The final task force report directs several state agencies, the Ohio General Assembly, health care organizations and other entities to work collaboratively on implementing the recommendations outlined in the report. The AMCNO plans to be involved in this process.

129th General Assembly

At press time we were just a few days away from Election Day and early voting was well underway with anticipated outcomes still very much up in the air. Regardless of the outcome of the election, Ohio's leaders, whomever they may be, will receive as a reward for being elected a projected deficit of approximately $8.5 billion dollars over the next biennium. That shortfall amounts to approximately 16% of the state operating budget.

Given the amount of money that is allocated to programs and services that are intended to provide various healthcare-related benefits to residents, we expect much discussion on how to address this shortfall to focus on programs that directly impact our membership. Specifically, Ohio's Medicaid budget, which makes up approximately 26% of the total amount spent by the state, is most certainly going to be looked at through a number of lenses for potential cost-saving opportunities.

Complicating matters is the fact that the recently passed Patient Protection and Affordable Care Act (PPACA) prohibits states from reducing benefits to Medicaid recipients to a level below what those benefits were prior to the passage of PPACA. What is not prohibited in PPACA, however, is a reduction in reimbursement costs paid to Medicaid providers by the state. While no specific discussion has occurred regarding whether or not reimbursement rates should be reduced in an effort to reduce the deficit, budget experts in Columbus are well aware of this opportunity as a potential cost-saving measure.

Medicaid reimbursement will not be the only fiscal issue deliberated on that could impact the medical community. Hospital franchise fees continue to be viewed as a major revenue source for the state, and that revenue stream could actually grow in the next biennium. Additionally, taxing of services offered by industry professionals is not off the table, potentially increasing the cost to provide health care services moving forward. It is probable that this could be one of the most challenging operating budget deliberations that Ohio has seen in a generation.

The AMCNO and its team of lobbyists will be monitoring these issues very closely over the coming months and will continue to provide updates to our membership as news develops. ■

AMCNO Promotes Physician Advocacy

Dr. Fred Jorgensen, a representative from District I serving on the AMCNO board, arranged for the AMCNO to conduct a presentation for family medicine residents and faculty at the Fairview Center for Family Medicine on the topic of physician involvement in advocacy and legislative activities. Presenting on behalf of the AMCNO were Dr. John A. Bastulli, Vice President of Legislative Affairs and Mr. Mike Wise, AMCNO Lobbyist.

Dr. Bastulli noted that while physician advocacy activities are not included in medical school training, it is a reality that if physicians do not get involved in the legislative process those who did not attend medical school will decide the future of the practice of medicine. He noted that whether the physicians in the room realized it or not many health care issues and medical care options are decided by the legislature and government entities — so it is imperative that physicians get engaged in the process. Physicians have two choices — they can either get engaged or leave it to the legislators and government to set our agenda. The AMCNO believes that physicians should get engaged in the legislative process and advocate on their own behalf.

Dr. Bastulli outlined the advocacy activities conducted on behalf of physicians by the AMCNO — noting that the AMCNO Legislative Committee reviews all health care-related legislation introduced in Ohio and provides our position to Ohio legislators as well as presenting testimony in Columbus. He commented that most physicians do not want to drive down to Columbus and talk to legislators about health care issues. And for the most part most physicians do not want to interact with government entities. However, physician input is crucial to affect change in state and federal legislation. He noted that physicians can achieve enhanced representation by communicating with legislators.

Mr. Wise, a former Ohio legislator, echoed Dr. Bastulli's comments noting that if physicians want to get involved, legislators would welcome physician input. Physicians are woefully underrepresented at the State House so it is helpful for physicians to get to know their legislators through a telephone contact, an email or by requesting a personal meeting with your state representative.

Dr. Bastulli noted that the AMCNO is an independent organization that represents the physicians in Northern Ohio. Our lobbyists represent your interests — they work with legislators to affect changes that will benefit patients and physicians while achieving a balance that will assist physicians and patients throughout the state. He noted again that there are many special interest groups who are working very hard and stepping up their lobbying efforts to line up against organized medicine and it is imperative that more physicians get involved in the legislative process.

Both presenters briefly outlined how a bill becomes law and provided detailed information on how physicians could gain access to legislators. Dr. Bastulli also briefly mentioned issues that the AMCNO legislative committee has worked on recently such as the physician ranking legislation noting that the AMCNO worked with both Representative Boyd and Senator Patton to introduce this legislation in both the Ohio House and Ohio Senate. He also outlined the importance of the upcoming Ohio Supreme Court races illustrating the importance of electing Justice Maureen O'Connor as Chief Justice and retaining Justice Judith Lanzinger on the Ohio Supreme Court. These individuals are dedicated to further establish and preserve the principles of judicial fairness. He noted that the AMCNO's Political Action Committee (NOMPAC) has been very active in this campaign. He also mentioned that the AMCNO would be sending out a 2010 Voting Guide in the near future.

Concerns of the residents in attendance included quality of care issues, the amount of paperwork processed by physicians on a daily basis, future physician payment structures, the overall cost of healthcare, where the practice of medicine would be in ten years and the cost of medical education.

***Dr. John Bastulli**, AMCNO Vice President of Legislative Affairs and Mr. Mike Wise AMCNO Lobbyist (far left of photo) pose with the residents at the Fairview session.*

Dr. Bastulli stated that all of these concerns are greatly impacted by government regulations and legislation. He noted that it is true that physicians are trained to focus on the care of the patient. And, it is true that physicians are trained to place medical care and the patient outcome above all else. But the welfare of your patients and the medical care environment has eroded and decayed due to the outlay of funding by other special interest groups. Physicians must meet this this challenge head on and he encouraged the residents to have an interest in politics and "advocate for your profession at the legislative level and get involved in organized medicine groups such as the AMCNO." ■

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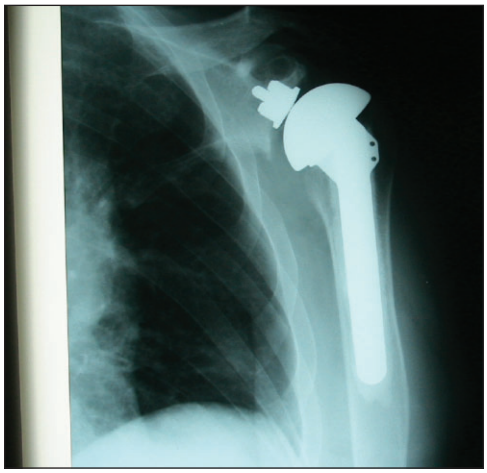
Total Joint Replacement in the Upper Extremity

William H. Seitz, Jr., M.D.
Professor of Orthopaedic Surgery
Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

Total Joint Replacement has undergone many evolutions in the hip and knee, however, its application in the upper extremity has only recently begun to catch up with some of these advances. In the last 10 years, there has been a dramatic surge in technology, science and its application to develop and deliver the ability to preserve motion, reduce or eliminate pain, and restore function in patients who have previously been relegated to stiff and dysfunctional joints especially involving the shoulder, elbow and wrist.

Arthritic degeneration of the shoulder, elbow and wrist results in significant loss of hand function. Loss of mobility in these joints makes daily activities including hygiene, grooming, eating, and dressing extremely difficult, resulting in pain, weakness, and substantial loss of mobility and function. In the past, the surgeon has been relatively limited in his/her ability to provide a joint reconstruction which is both mobile, stable, and long lasting for patients with arthritis of these joints.

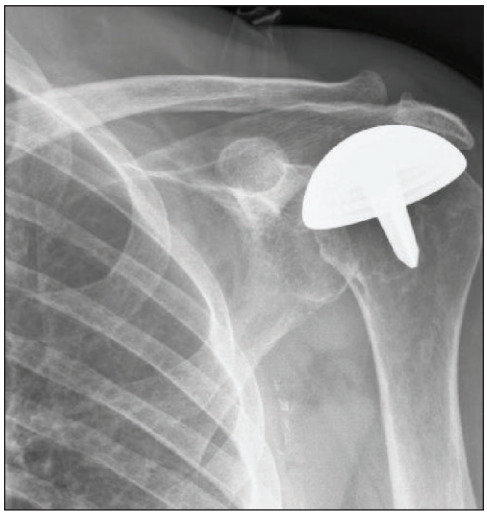
Older forms of arthroplasty of the shoulder provided a narrow range of sizes which frequently were not physiologic and required the patient's own anatomy to be fitted to the existing implants. Many forms of arthritis in which soft tissue was lacking (such as following extensive rotator cuff degeneration and rupture) had limited choices for repair and reconstruction, and even those provided limited choices and were not physiologic. New advances in engineering, understanding of the patho-physiology and the application of biomechanical principles to the design and fabrication of implants have substantially improved the surgeons' ability to care for such challenging patients.



(Figure 1) Total Shoulder Arthroplasty

In the shoulder, more standard forms of arthritis can now be managed with modular systems that enable exact matching to the patient's anatomy through less invasive incisions with early return to function.

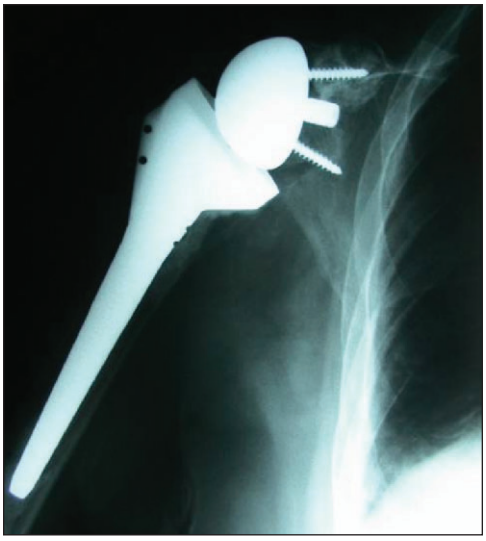
In younger patients who have arthritis and in whom it is desirable to preserve as much bone stock as possible, minimally invasive resurfacing cup arthroplasties are capable of providing a new seamless and smooth articular surface without need to re-sect large segments of bone.



(Figure 2) Cup Arthroplasty

In patients in which the arthritis which follows massive cuff tear or in some patients, with rheumatoid disease and poor rotator cuff quality, a reverse shoulder arthroplasty can be used which provides added stability and allows movement and prevents dislocation despite the absence of a functioning rotator cuff.

This approach to shoulder replacement arthroplasty has evolved to counteract the loss of force couple normally provided by the rotator cuff which keeps the spherical head of the humerus centrally seated in the glenoid and replaces it with a capturing "socket" in the upper humerus which is able to maintain purchase on the sphere imbedded in the scapula providing a constant functional fulcrum allowing the deltoid to take over movement of the shoulder.

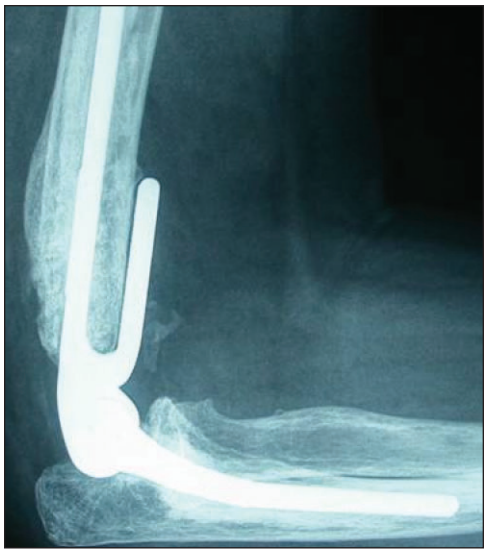


(Figure 3) Reverse Total Shoulder

Elbow arthroplasty, initially designed for low demand patients with rheumatoid arthritis has been extremely successful over the past two decades. Recently, we have seen more and more younger patients with post-traumatic arthritis and osteoarthritis of the elbow to whom such reconstruction can be applied. However, once these more active patients have undergone their arthroplasty, they tend to become more active, applying extreme degrees of stress to their reconstructed elbows and as a result, there has been a higher rate of implant "wear out" and need for revision. Existing implants have undergone an evolution and have improved substantially but still represent a form of "hinge" mechanism to allow the elbow to go through the excursion of flexion extension and supination.

Recognition of the success in alleviating pain and improving motion in more active patients has prompted the design and evolution of newer implants which are more physiologic and combine both the stability of a coupled implant with the force distribution of the normal anatomy.

In addition, newer, less invasive techniques of arthroscopic debridement and replacement



(Figure 4) Total Elbow with Hinge Mechanism

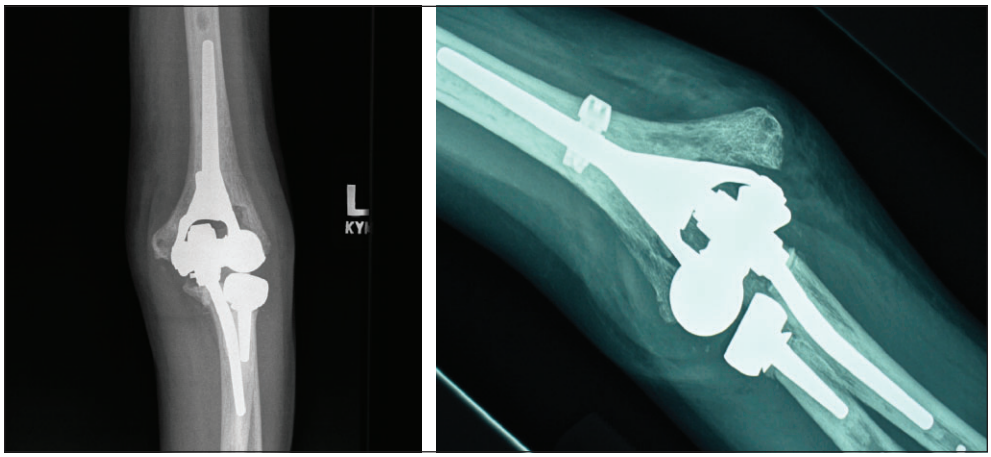
of just the radial head component of the elbow, have allowed partial arthroplasty with preservation of some of the patients' own joint for an extended period of time, postponing the need for total joint replacement. These implants can be fabricated as custom implants when needed.

Total wrist arthroplasty is the youngest of the total joint replacement procedures performed in the upper extremity. The wrist is quite complex because it involves interaction of five metacarpals, eight carpal bones, the two bones of the forearm at the wrist and the complex interaction of ligamentous and cartilaginous structures about which tendons, nerves and vascular structures traverse in order to provide both fine hand prehension and grasping and tactile activities of the hand. New designs have been able to restore more normal anatomy by moving the center of rotation of implants to the anatomic location of the head of the capitate while providing the newest technology for secure osseous integration to maintain a tight purchase on the implant. Additionally new implants have evolved to replace the ulnar head when needed, with availability of corporate or custom implants as needed. This has restored the ability to have functional wrist motion in flexion and extension, radial and ulnal deviation, supination, pronation for normal placement of the hand, and space for function.

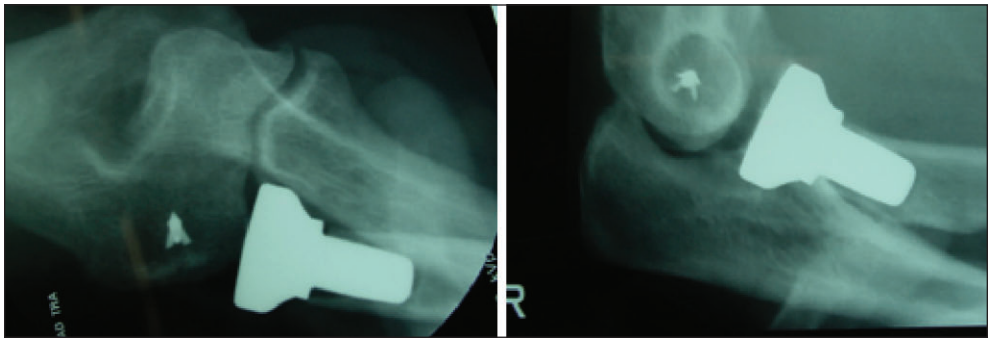
There are, on average, about three-quarters of a million hip and knee procedures performed in the United States annually. There are only about 10,000 total shoulder replacements, 1,000 total elbow replacements, and just a few hundred wrist replacements performed annually in comparison. There is therefore clearly a greater demand for total joint implants in the lower extremity, by the same token, when a patient has severe arthritis in one of these upper extremity joints, it provides just as much, if not more disability than is encountered in the lower extremity. The ability to replace rather than fuse or resect diseased joints in the upper extremity has significantly improved the quality of life for many patients. As the field of upper extremity surgery advances, we look to develop new technologies through education and research to further enhance our ability to restore motion to our patients' arthritic joints.

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.*

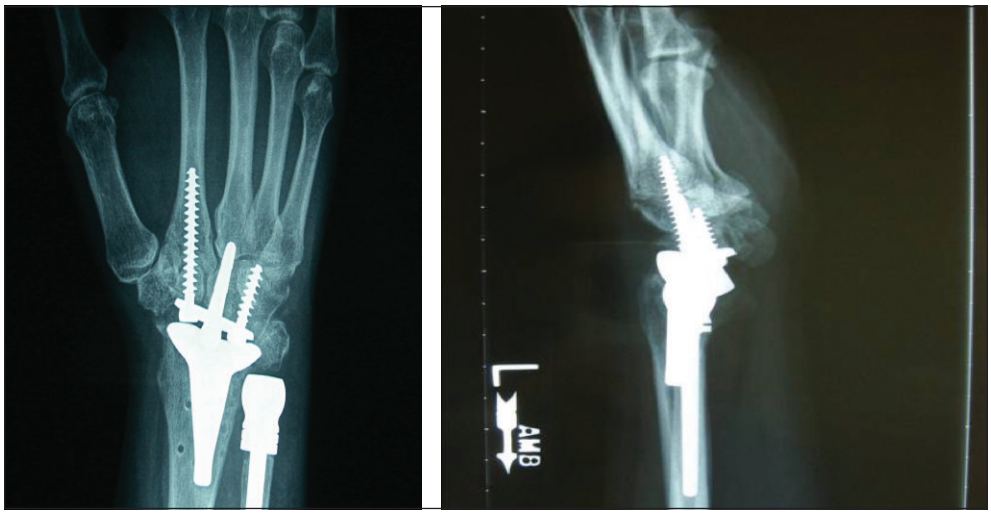
AMCNO members interested in submitting an article for publication in the magazine may contact Ms. Cindy Penton at the AMCNO offices at (216) 520-1000, ext. 102. ■



(Figure 5A & B) Anatomical Elbow



(Figure 6A & B) Radial Head Replacement



(Figure 7A & B) Total Wrist Arthroplasty

AMCNO BOARD ACTIVITIES

Congress Must Act on Medicare Payment Cut Issue

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has written to Congress on numerous occasions regarding the impending Medicare payment cuts. The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192) stabilized Medicare physician payments only until November 30, 2010. Beginning December 1, 2010, unless something changes under the law, Medicare payments for physician services will be slashed by more than 23 percent. To make matters worse, an additional cut of 6.5 percent could follow on January 1, 2011. The AMCNO realizes that our members cannot continue to accept this situation.

The AMCNO has stressed to Congress that they must act — they must break the yearly cycle of putting a band-aid on this problem — they must take action on legislation to provide permanent stability in the Medicare program. Unfortunately, during 2010, Congress once again enacted short-term measures with regard to the Medicare payment issue and on several occasions they did not act in time and Medicare payments were cut by more than 20 percent. As a result of this lack of Congressional action, the Centers for Medicare and Medicaid Services ordered carriers to hold payments until legislation was passed. This payment delay caused disruption in physician practices across Northern Ohio.

The next payment reduction scheduled for December 1, 2010 falls during the timeframe when physicians will have an option to change their Medicare participation status. It is possible that physicians will be considering whether they can continue to accept Medicare rates at the same time that massive payment cuts are scheduled to take effect. The AMCNO has informed Congress that it is time to permanently replace the Sustainable Growth Rate (SGR) formula once and for all. The AMCNO will continue to ask Congress to take action on this issue before there is a need for yet another stopgap measure. AMCNO members are urged to contact their Congressional representatives and ask them to take action before November 30, 2010.

Availity Making Inroads in Ohio

In September, Ms. Janice Popa, Availity Market Executive for Ohio and Wisconsin, met with the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), board of directors to provide an update on the statewide initiative to implement Availity. The AMCNO is a part of this initiative which is between the American Association of Health Plans (AHIP), the Blue Cross and Blue Shield and eight leading health plans in Ohio. Ms. Popa provided the board with an overview of the Availity portal and the status of the project in Ohio. She noted that the Availity portal offers the following transactions:

- Eligibility and benefits;
- Claim status
- Web-entered claims
- Authorizations and referrals (this is not yet available for all participating plans)

Ms. Popa noted that the Availity health information network and web portal will help physicians achieve administrative savings by simplifying the exchange of information between providers and payers. She noted that the Availity Health Information Network provides free access to the state's leading health plans for the exchange of administrative information in real-time. The health plans currently participating in the multi-payer portal include: Aetna, Anthem Blue Cross and Blue Shield, CIGNA, Humana, Kaiser Permanente, Medical Mutual of Ohio, UnitedHealthcare and WellCare Health Plans, Inc.

This collaboration among the health plans is designed to simplify the exchange of real-time information with health plans through Availity's secure provider web portal. The portal is easy to use; health care providers can start saving time and money with minimal training and without changes to their office systems. Availity does provide physician practices with training to get up and running — and they also offer integration options with numerous practice management systems.

Over time, the participating partners in the project plan to measure provider adoption and gather information on the use of electronic tools. The information garnered from this evaluation process will influence the development of similar portals in other parts of the country.

All providers in the state of Ohio are eligible to participate. To learn more about the project go to www.availity.com.

AMCNO Board of Directors Sends Letter to the U.S. Secretary of the Treasury Regarding Proposed Change in Federal Tax Policy

The AMCNO board of directors opted to send a letter to the U.S. Secretary of the Treasury, Timothy Geithner, regarding recent reports that the Treasury Department is considering a change in federal tax policy to allow a special tax deduction for trial attorneys who enter into gross fee contingency contracts with clients. The AMCNO notified Mr. Geithner that our organization shared the concerns voiced by numerous national and state medical associations that the Treasury Department may reverse its long-standing policy maintaining that court and other litigation expenses advanced by trial attorneys are not deductible as business expenses. According to various sources, this change is estimated to cost taxpayers over $1.5 billion and could act as a financial incentive for trial attorneys to file less meritorious lawsuits against physicians.

The AMCNO echoed the concerns of the state and national associations and we urged the Department to reconsider any plans to issue an official guidance or rule that would change current policy relating to the deductibility of litigation costs for trial attorneys.

Accountable Care Organizations At-a-Glance

A lot has been said lately regarding the success of the U.S. healthcare system, and, in particular, the bang Americans get for their healthcare buck. Many experts, policymakers and others believe we could do better in terms of the value we're reaping from our system. In fact, they've argued that healthcare reform cannot be entirely effective without a mechanism that rewards providers for achieving good outcomes for patients.

This is where accountable care organizations (ACOs) come in, according to their proponents. ACOs are intended to reward providers for quality care and successful outcomes, differing fundamentally from the current system, which pays providers based primarily on their volume of services. ACOs have their roots in a model already in place in some health systems, including the Cleveland Clinic locally as well as the Mayo Clinic and Geisinger Health System. These organizations differ from most hospitals nationwide in that physicians are employed, rather than simply having privileges, the delivery system is more integrated, and there are incentives other than volume driving physician compensation. This model gained national attention as health reform was being debated and has lent steam to the developing ACO movement.

But for many the question remains: what are ACOs and how do they work?

ACOs, in a Nutshell

If you find yourself unsure about what an accountable care organization is, you are not alone. The concept of ACOs has been evolving rapidly at the same time that interest in the notion has heated up. Adding to the confusion, the term has changed names several times and other concepts with similar goals now fall under the ACO umbrella (1). An accountable care organization is a local healthcare organization and a related set of providers (typically hospitals, primary care physicians and specialists, at a minimum) that can be held accountable for the cost and quality of healthcare provided to a defined population (2). While this concept is not new, what is unique about this reform approach is that it puts the locus of accountability for both the cost and quality of care on a local group of providers and delivery systems, rather than an individual provider or insurance company (3).

Accountable care organizations can take many shapes and forms, but they hold in common the goal of providing healthcare that is coordinated and efficient. To achieve coordinated care, ACOs need to have the ability to care for patients in various institutional settings across the continuum of care. ACOs also need to be able to plan for budget and resource needs, set benchmarks, measure performance, and administer payments (4).

Cost savings and quality improvements that result from more integrated care can result in incentive payments and, in some models, financial penalties for poor performance. Given these potential financial repercussions, accurately measuring the quality of care provided is a crucial issue. To ensure that any cost savings achieved are the result of quality improvements and not simply year-to-year fluctuations in care, ACOs need to be of a sufficient size to ensure that performance measurement is valid and reliable (5). Some experts believe that ACOs need to have at least 5,000 Medicare beneficiaries or, for those serving patients in the private market, at least 15,000 commercial beneficiaries in order to guarantee accurate performance measurement.

Accountable care organizations differ from other organizations that are similar based on the flexibility built into their payments, structure and risk assumption (6). This flexibility allows local markets to tailor their ACOs and payment structures in a way that makes the most sense for that market.

Healthcare Reform Advances ACO Concept

Accountable care organizations owe their recent moment in the spotlight in large part to the recently enacted healthcare reform legislation. As healthcare reform conversations heated up on Capitol Hill, the idea of leveraging accountable care organizations to help control Medicare spending gained traction. Language included in the final bill allows for a demonstration project to test ACOs as a mechanism to control Medicare spending.

Dubbed the Medicare Shared Savings Program, this demonstration project will begin January 1, 2012. Each participating ACO will have at least 5,000 fee-for-service Medicare beneficiaries assigned to it and will need to agree to participate for not less than three years. Participating ACOs are responsible for the quality, cost and overall healthcare of their assigned beneficiaries and are eligible to received payments for shared savings if they meet quality performance standards. This demonstration project will be used to determine what works best in which part of the country.

Eligible ACOs authorized under the healthcare reform legislation include: ACO professionals in group practice arrangements; networks of individual practices of ACO professionals; partnerships or joint venture relationships between hospitals and ACO professionals; hospitals employing ACO professionals; and other groups deemed appropriate by the Secretary of Health and Human Services. Many details remain to be ironed out, including the specific performance standards that will be used to assess the quality of care provided by ACOs.

In addition to the Medicare Shared Savings Program, a lesser-known provision in the law calls for the creation of a pediatric accountable care organization demonstration project within the Medicaid program. This pilot project will run from January 1, 2012 until December 31, 2016.

ACOs Emerge Across the Country

While the ACO projects under health reform aren't slated to begin until 2012, several states and private organizations have already implemented, or are in the planning stages of implementing, their own ACO models. Given the flexibility that is built into the ACO concept, various designs and payment structures are emerging.

Brookings / Dartmouth Pilot Projects

The Brookings Institution's Engelberg Center for Health Care Reform and the Dartmouth Institute for Health Policy and Clinical Practice are piloting ACO programs in the private sector. Three health systems were initially chosen to test the model: the Carilion Clinic Health System in Roanoke, Virginia; Norton Health System in Louisville, Kentucky; and Tucson Medical Center in Arizona (7).

Premier ACO Collaboratives

Premier healthcare alliance and 19 health systems — including University Hospitals

(Continued on page 14)

Accountable Care Organizations At-a-Glance *(Continued from page 13)*

and Summa Health System in Northeast Ohio — this spring announced the launch of two ACO collaboratives designed to provide integrated care for 1.2 million beneficiaries. These collaboratives will have several key components including: a patient-centered focus, health homes that deliver primary care and manage health and wellness, tightly integrated provider relationships, a focus on value over volume, and health information exchanges.

The ACO Implementation Collaborative will allow providers who already have the necessary capabilities to immediately begin providing coordinated care. The ACO Readiness Collaborative, which another 40 health systems joined in August, is designed for health systems that do not yet have the necessary organization, skills, team and operational capabilities necessary to become ACOs. The goal is for ACOs in the Readiness Collaborative to ultimately join the Implementation Collaborative.

The Premier ACO collaboratives will ensure that best practices are shared among participants, allowing models to evolve over time in order to most effectively improve quality, control costs and ensure a high level of patient satisfaction. These new models will be tested with private payers.

State Pilot Projects

At least two states have begun experimenting with, or are considering implementing, accountable care organization pilot projects. Based on findings from a study conducted by Vermont's Health Care Reform Commission, the state passed legislation authorizing the creation of at least one ACO to be piloted in the state. Three Vermont provider organizations have begun creating an ACO with the goal of implementing the first site in 2011.

Colorado's Accountable Care Collaborative is planning to implement a program at the beginning of 2011 that can be expanded if successful in achieving key goals. Colorado's version of ACOs, regional care coordination organizations, will aim to provide a medical home for Medicaid patients, integrated care, and regional accountability for patient outcomes and healthcare costs. Currently, the state is proposing seven such organizations.

Refining the ACO Model

The flexible nature of ACOs means that they can take a variety of forms. This inherent flexibility has resulted in a situation in which many details remain to be worked out both in models that have been authorized through legislation and in models that are being contemplated in the private market.

How much financial risk the provider takes on is just one of the issues that accountable care organizations need to resolve. Some models call for implementing a system in which payment is based on the traditional fee-for-service Medicare payments, with providers taking on no additional risk yet being able to participate in a shared savings program. Other models call for limited or substantial capitation arrangements with providers taking on some financial risk.

Aside from the issue of financial risk, ACOs need to grapple with which provider configuration will achieve the best outcomes. Integrating care is key to achieving efficiencies. Yet some say that the healthcare reform law doesn't resolve some of the legal issues that have stood in the way of tighter physician / hospital relations in the past, such as those stemming from antitrust, fraud and abuse laws.

How beneficiaries are brought into the ACO is another detail that different models need to resolve. Will patients be given a choice about whether or not to participate in an ACO or will the choice be made for them? For those beneficiaries who are required to join an ACO, whether or not they are assigned to an ACO or can choose an ACO is another issue that will need to be decided.

Then there is the not insignificant issue of how to assess quality of care. How performance is measured, including where benchmarks are set, will be crucial to the success of each ACO model.

What Health System Reform Says About ACOs

Several private and government-sponsored accountable care organization pilot projects are under way, and the Patient Protection and Affordable Care Act (PPACA) calls for even further implementation of this payment model.

Although there are still questions as to how the health system reform law will progress, the law does include some key points relative to ACOs as follows:

Groups of physicians and health care professionals may become ACOs eligible to receive payments on top of those received for usual services if they meet yet-to-be-determined performance standards. The standards will be elevated over time and adjusted according to several patient risk characteristics.

An ACO will need to define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.

Entities that are eligible include group medical practices, networks of individual practices, partnerships or joint venture arrangements between hospitals and health care professionals, hospitals that employ physicians and other multiparty arrangements as deemed appropriate.

By January 1, 2012, the Department of Health and Human Services will establish a shared savings program for Medicare Part A and B beneficiaries.

By January 1, 2012, HHS will establish the Pediatric Accountable Care Organization Demonstration Project.

Participating states will be authorized to allow those who provide care to children and adolescents and meet specified requirements to be recognized as an ACO similar to those established for patients on Medicare. This demonstration project will end December 31, 2016.

Qualifying ACOs need to provide care for a minimum of 5,000 beneficiaries and commit to at least three years of participation in the program.

An ACO may be sanctioned if HHS determines that steps were taken to avoid higher-risk patients.

Conclusion

In the current healthcare system, even under many reform ideas, the individual provider is the locus of both performance assessment and accountability. This creates little incentive for coordinated care, particularly given the "siloed" reimbursement structure that providers need to operate within. Accountable care organization proponents are attempting to change this by placing providers back at the center of care decisions while holding groups of providers and delivery systems accountable for the quality and cost of that care.

As the concept has gained traction, various stakeholders have begun grappling with how to most effectively structure accountable care organizations. Change will not happen overnight. Many healthcare delivery systems will need to evolve in order to handle new payment and other responsibilities. Large, integrated provider systems already have many of the capabilities needed to function as ACOs, but small- to medium-sized systems will likely need support to move to an ACO model. As public and private entities gain experience testing the ACO concept, it is expected that ACO models will evolve in order to achieve the greatest results.

Will ACOs really succeed in improving the quality of healthcare while decreasing costs and increasing patient satisfaction? Given the infancy of the movement, perhaps the safest assumption to make about ACOs is that the jury is still out on how effective they will be at both holding down costs and improving quality of care, but they are certainly worth a try. ■

Endnotes

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Editor's Note: *This article was reprinted with the permission of the Center for Health Affairs. (Note: The pullout box on page 14 was taken from PPACA).*

Five Financial Strategies for 2011

2011 brings an opportunity to get your finances on track. These five easy-to-implement strategies could yield benefits for years to come.

The past few years of market volatility may have dealt a blow to your investment portfolio, while leaving you confused over how to manage your finances in a rapidly changing economic landscape. 2011 provides an opportunity to take action to get your financial life in order.

"Now is an ideal time to review your finances and make a plan," says Philip Moshier, CFP®, a financial planner with Lincoln Financial Advisors Corp. in Cleveland. Moshier offers the following five financial strategies for helping to get into financial shape.

- **Review your investment strategy.** The first step is to check your portfolio's asset allocation, or its mixture, on a percentage basis, of stocks, bonds, and cash investments. Along with stocks, bonds and mutual funds be sure to consider other asset classes such as real estate and commodities. When looking at your allocation, you want to take into consideration all of your assets including your retirement accounts, savings accounts, and pensions plans as well as brokerage accounts. What's the right mix? That depends on your financial goals, time horizon and tolerance for risk, among other variables. Completion of a risk tolerance questionnaire, available from your advisor, is a good starting point in determining your optimum asset allocation. Your advisor can help you decide whether your current investment balance is appropriate — and can help you implement changes if it isn't. No plan or strategy can assure a profit or protect against losses in a declining market.

- **Rebalance, if necessary.** Your review may reveal that market events have skewed your targeted asset allocation. The result? A portfolio that's too aggressive or too conservative for you. "Asset classes will get out of balance periodically," says Moshier. "They won't fix themselves — you need to take action to get your allocations in line with your strategy."

  Moshier recommends annual or semi-annual rebalancing. Check to see how the market's movements shifted your asset allocation. If they differ significantly from your targets — say, five percentage points or more — you can add new money to or sell off assets in out of balance categories. Rebalancing may have tax implications so it is important to coordinate your financial planning strategies with your income tax effects.

- **Create a retirement income plan.** Your retirement plan income will likely come from 3 buckets — your company retirement plans or your IRAs, outside investment accounts and Social Security. The proper coordination of these plans will provide you with the most efficient streams of income from both a tax and an investment point of view. There are many decisions to make at retirement which a financial advisor can assist with but the decisions made while accumulating assets are equally, if not more, important. Moshier recommends taking steps now to help ensure that you'll have sufficient assets to fund your retirement lifestyle. Talk to your financial planner to assess your current retirement income plans viability and make adjustments as needed.

- **Maximize tax-advantaged plans.** Traditional 401(k)s and traditional IRAs let you contribute pretax money that has tax-deferred growth potential. You'll pay income tax on withdrawals from these plans. Roth IRA contributions are after-tax income, but they have tax-free growth potential. Whichever accounts you use, contributing the maximum allowable makes best use of the accounts. Many employers also offer matching incentives for employees who contribute to their 401(k) plans. Moshier recommends contributing as much as you can to these plans and maximize the employer match programs.

  Remember that investors of all income levels can convert traditional IRA accounts to Roth IRAs. Ask your advisor if a conversion is appropriate for you. While the decision can be complex, you may find that converting may offer potential benefits.

- **Take advantage of low asset values for estate planning.** The recent economic downturn has decreased asset values, including real estate, family businesses, and other holdings. Certain estate planning strategies may enable you to lock in low asset values to help reduce your heirs' eventual estate taxes. "It's been the perfect storm for some estate planning strategies," says Moshier. "Now you can pass along much more of your wealth, and its future growth can potentially avoid estate taxation." Ask your advisor whether the time is right for you to put a wealth-transfer strategy in place.

Taking these simple steps to help control your finances may yield benefits not only in the coming year, but for years to come.

Three questions to ask your financial planner:

- Does my portfolio hold the appropriate mix of stocks, bonds, cash, and other assets?
- Do I need to rebalance? If so, what is the most efficient method?
- How can I save more for retirement?

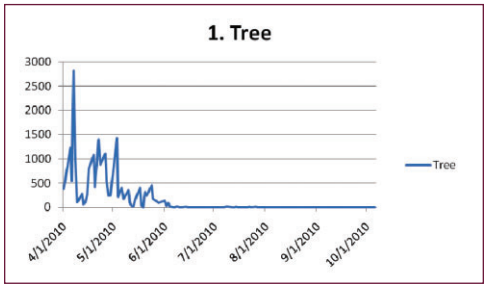
Philip Moshier is a registered representative and investment advisor representative with Lincoln Financial Advisors Corp., a broker-dealer and registered investment advisor, 28601 Chagrin Boulevard, Suite 300, Cleveland, OH 44122, (216) 765-7400, offering insurance through Lincoln affiliates and other fine companies. This information should not be construed as legal or tax advice. You may want to consult a tax advisor regarding this material as it relates to your personal circumstances. The content of this material was provided to you by Lincoln Financial Advisors Corp. for its representatives and their clients. ■

AMCNO 2010 Pollen Line Recap

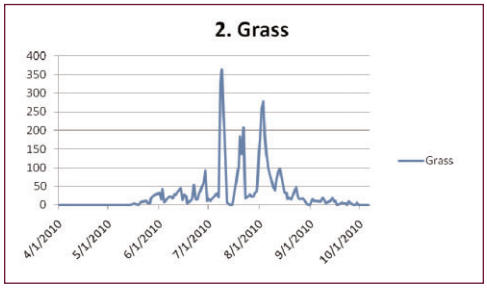
Leah Chernin, DO & David Swender, DO
Allergy/Immunology Associates, Inc.

Another pollen season has come and gone. The pollen count is obtained using a Rotorod Aeorallergen device located on the roof of the Suburban Health Center on Green Road in South Euclid. The rotor spins, sampling the air and collecting pollen. The pollen is then counted and reported to the public by Allergy/Immunology Associates each morning. The pollen count is used by local physicians to help guide the treatment plans for their patients with environmental allergies. This year's pollen count started April 1, 2010 and will continue through the fall.

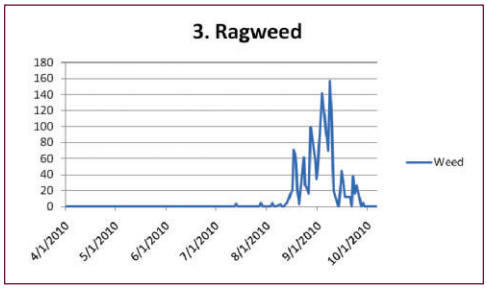
The pollen season kicked off with high counts of tree pollen. The typical Ohio tree season starts in early spring and continues until the early summer months. This year's tree season peaked in April. The pollen count slowly declined through May, with the season ending at the beginning of June. See graph 1.



The tree season was followed by the grass pollen season. The grass season started in mid-May and peaked in July. We had a prolonged grass pollen season this year. Grass counts remained high through August and declined through the beginning of October. See graph 2.



The ragweed season started in early August and peaked in early September. Due to the rainy weather in the early fall, the ragweed pollen count was inconsistent this September. The ragweed pollen count tapered through the beginning of October. See graph 3.



As we enter into fall, the mold count has started to rise. We expect the mold count to thrive and increase, due to the moist fall leaves.

A sustained frost will mark the end of the 2010 pollen season. We will resume pollen counts again on April 1, 2011. The pollen count can be obtained by calling the pollen line at (216) 281-1050 or at www.amcnoma.org. We hope for a light winter and look forward to the start of pollen season in 2011. ■

AMEF
Academy of Medicine Education Foundation

Include AMEF in Your Charitable Giving Plans

AMEF uses funds to provide medical scholarships to assure that our medical schools continue training physicians to meet the need of patients in the future. In addition, your donation may assist with other worthwhile foundation activities that support public health and education initiatives. Look for AMEF's annual newsletter, *Foundation Facts,* in your mail soon and remember your profession in your giving plans

Academy of Medicine Education Foundation 2010 Scholarships

Scholarship applications can be obtained from the registrar or financial aid offices of eligible schools. **The filing deadline is January 31, 2011** for medical students meeting AMEF scholarship eligibility criteria:

1. AMEF awards scholarships each year to Third and Fourth year medical students (MD/DO) who are or were residents of Cuyahoga, Summit, Lake, Geauga, Ashtabula, Lorain or Portage counties, and who demonstrate an interest in organized medicine, leadership skills, community involvement and academic achievement.
2. AMEF scholarships will be awarded to Third and Fourth year medical students attending the following institutions: Case Western Reserve University School of Medicine, Cleveland Clinic Lerner College of Medicine, Northeastern Ohio Universities College of Medicine and Ohio University College of Medicine. ■

Wishing A Happy & Healthy Holiday Season

To all Members of the

Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

From: Your AMCNO Board of Directors and Staff

UNITED STATES POSTAL SERVICE® **Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)**

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Contact Person: Elayne Biddlestone
Telephone *(Include area code)*: 216-520-1000 x-100

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Elayne R. Biddlestone, EVP/CEO
The Academy of Medicine of Cleveland & Northern Ohio
(same address as above)

Managing Editor *(Name and complete mailing address)*
Same editor information as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
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11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

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12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
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☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

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I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

PS Form **3526,** September 2007 *(Page 2 of 3)*

CWRU medical students join the AMCNO

More than 60 students, faculty, friends and family attended this year's medical school picnic of Case and the Lerner College of Medicine September 12th. An annual event held this year in the Cleveland Metroparks Ohio & Erie Canal Reservation, offered students a late summer retreat of food and outdoor fun including volleyball, soccer and tug-o-war games. The AMCNO hosted a raffle awarding prizes of gift certificates to popular local eateries. During the festivities, AMCNO membership staff enrolled 30 new members. Medical school students as well as residents can enjoy the benefits of AMCNO membership at no cost throughout their training. In part, these benefits include weekly medical news updates via email, legislative representation at the state house, a listing in our physician directory and the advantage of AMCNO advocacy for the issues specific to Northeast Ohio physicians. Welcome new members!

Winners of the AMCNO raffle prizes smile for the camera at the CWRU medical student picnic.

Call for 2010 AMCNO Honorees

The AMCNO invites you to nominate an individual who is a member of the AMCNO that you believe is deserving of special recognition by the AMCNO. Any physician who wishes to nominate an individual for one or more of these awards should complete the form below and mail it to me at the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call her at (216) 520-1000, ext. 100 to provide your honoree nominations over the phone. Deadline for submission:12/31/10.

- **JOHN H. BUDD, M.D., DISTINGUISHED MEMBERSHIP** – This award is bestowed upon a member of the AMCNO who has brought special distinction and honor to the medical profession, to our community and to our physician association as a result of his or her outstanding accomplishments in biomedical research, clinical practice or professional leadership. Often, such an individual has already gained national and/or international recognition because of the importance of his or her contributions to medicine.
- **CHARLES L. HUDSON, M.D., DISTINGUISHED SERVICE** – Awarded to a physician whom the AMCNO deems worthy of special honor because of notable service to and long activity in the interest of organized medicine.
- **CLINICIAN OF THE YEAR** – Awarded to a physician whose primary contribution is in clinical medicine and whose service to his/her patients over many years has reflected the highest ideals and ethics of, and personal devotion to, the medical profession.

- Your Name: _____
- Your Nomination: _____
- Nominated for the following award: _____

Please include an explanation as to why you are nominating this individual _____

_____

_____

_____

Are you Interested in Running for the AMCNO Board of Directors in 2010

Directors are elected to represent their district, which is determined by primary hospital affiliation or at large for a two- year term. Members of the Board are responsible for addressing issues of importance to physicians and the patients we serve, and setting policy for the AMCNO. If you are interested in running for the board of directors please return this form with your name and contact information to the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 100. Deadline: 12/31/10

Yes, I am interested in running as a candidate for the AMCNO board of directors _____

Name and Contact information:_____

_____

Request a Workers' Compensation AMCNO Group Rating Quote Today!

With changes continuing to be made to the Ohio workers' compensation group rating program, now more than ever it is important to be with the **Academy of Medicine of Cleveland and Northern Ohio (AMCNO)** that supports your organization to ensure your workers' compensation program delivers superior results.

Through **AMCNO's** program, in partnership with the Professional Insurance Agents Association of Ohio, Inc., your organization can be evaluated for not only Group Rating, but also new programs recently added by the Ohio Bureau of Workers' Compensation including Group Retrospective Rating and the Deductible Program. Your participation in one of these programs as well as having the premier workers' compensation claims administrator working for you in **CompManagement, Inc.** is the best way to control and reduce your workers' compensation premiums.

Examine Your Opportunities

Why choose **AMCNO's** program, in partnership with the Professional Insurance Agents Association of Ohio, Inc., over others in the industry?

- **Multiple savings tiers** – ensuring that you receive the highest discount possible
- **Competitive fees** – ensuring a positive return on your investment with a focus on claims management and individualized service
- **A multi-tiered service model** – onsite and telephonic client support with a localized model that creates an awareness and relationship within your local community
- **A comprehensive risk management program** – alternative rating solutions that are right for your program, strong claims management and cost containment strategies, in-house safety and loss control services, unemployment claims management and consulting, and hearing representation
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Free, No-Obligation Evaluation – and it's easy to apply – simply visit http://resources.compmgt.com/AC3/GroupRating.aspx?Organization=AMCNO — click on the AC-3 form button and submit online.

We hope you make the same decision today as nearly 30,000 other Ohio businesses and organizations that have selected a program administered by CompManagement to assist them in reducing their workers' compensation premiums. If you have further questions, please contact CompManagement's Customer Support Unit at (800) 825-6755, option 3.

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