

AMCNO Physician Leaders Participate in Future of Health Care Reform Event

More than 80 physicians, practice administrators and medical association staff joined state lawmakers representing the Northern Ohio region to discuss the future of health care reform in Ohio and the impact of the Patient Protection and Affordable Care Act (PPACA) on physicians, hospitals and group practices. The forum, which was held at the University Hospitals Ahuja Medical Center and co-sponsored by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), provided a unique opportunity to hear firsthand from physicians and legislators from around Northern Ohio how health care reform could influence the practice of medicine.



Dr. Laura David, AMCNO President, provides the opening remarks at the Health Care Reform Event.

The forum was held in conjunction with the Ohio State Medical Association, University Hospitals and MetroHealth. The physician panel was moderated by the AMCNO President, Dr. Laura David and was comprised of physicians from across the Northern Ohio region, including AMCNO members Drs. John Bastulli, Michael Nochomovitz and James Ulchaker. Leaders from the Democratic and

Republican Caucuses were also on hand to contribute to the legislative panel discussion.

"With a new legislative year ahead, and the evolution of the Affordable Care Act — insurance mandates, the implementation of electronic medical records, and the need for more accessible primary care — we all realize that the big word for all of us is change," said

Dr. Laura David, AMCNO President. "Now more than ever we as physicians need to know the impact of the issues, and speak with the skill and the knowledge of the professionals that we are to assure that the very best of health care remains here in Ohio and that our medical expertise continues to climb and be at the center of what we have to offer to our citizens."
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AMCNO Co-Sponsors Electronic Health Record (EHR) Session

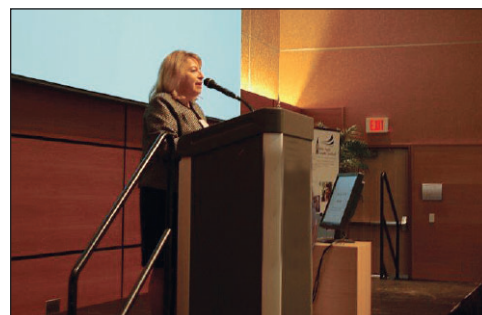
As part of our ongoing effort to educate our members on meaningful use and the implementation of electronic health records, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to participate in an event entitled "EHR: A Practice Survival Strategy: Bringing Joy Back to Primary Care."

The AMCNO co-sponsored this informative event with Better Health Greater Cleveland (BHGC) and the Case Western Reserve University Regional Extension Center (Case REC). Presenters at the event included Dr. Laura J. David, AMCNO president, Dr. Randall Cebul from BHGC, Ms. Cathy Costello from the Ohio Health Information Partnership (OHIP), and Mr. Joe Peter from the Case REC. The keynote speaker for the evening was Dr. Richard Baron, representing Greenhouse Internists. The event was funded through

BHGC by the Robert Wood Johnson Foundation.

Dr. David began the evening by welcoming the attendees and providing background on the AMCNO involvement in the physician community. She also outlined the role of the AMCNO with regard to meaningful use and electronic health record initiatives. She noted that the AMCNO works on behalf of physicians across the Northern Ohio region

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Dr. Laura David, AMCNO President, addresses the audience at the EHR Session.

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Meaningful Use Starts with a Certified EMR



To be eligible for incentive payments, physicians will need to fulfill certain “meaningful use” criteria using a certified electronic medical record (EMR) system. The Office of the National Coordinator (ONC) recently announced the first certified EMR systems.

Cleveland Clinic has been a recognized leader in the use of EMR technology since 2002. As you investigate your EMR options, please include MyPractice Community (powered by Epic Systems, an ONC-ATCB-certified solution) among your choices.

To learn more about MyPractice Community, and for a link to a list of ONC-ATCB-certified EMR solutions, please visit clevelandclinic.org/mpc. To speak to a MyPractice Community representative, please call 216.738.4617.



Every life deserves world class care.

AMCNO COMMUNITY ACTIVITIES

AMCNO Physician Leaders Participate in Future of Health Care Reform Event

(Continued from page 1)

Legislators participating in the forum noted that a major issue for Ohio in the coming year will be balancing the budget. The legislators agreed that Medicaid will be at the forefront of the budget discussion since it is such a complex program, and they fully understand that Medicaid reimbursement is important to physicians and hospitals. The legislators noted that they plan to look to the physician associations for input on this issue going forward.

The legislators also briefly discussed the impact of the federal reform bill on Ohio — specific to the amount of money provided to implement the health care reform program and the potential cost of the program — and how this could impact Ohioans. It was noted that the Ohio Caucus will look to leadership from the Attorney General and the newly elected Governor to determine whether or not Ohio would join other states on opposing mandates included in the federal bill.

Physicians participating on the panel provided their comments with regard to the Ohio

budget and the federal health care reform bill citing concerns with the hospital franchise fee, the predicted increase in the Medicaid patient load coupled with very low Medicaid reimbursement rates, and continuing concerns with the medical malpractice climate in Northern Ohio. Panel members also mentioned the intent to set up accountable care organizations and how this could impact physicians and their practice, the continuing problems with the Medicare payment model, as well as the cost of implementing electronic health records.

Overall, the participants agreed that although there have been and will continue to be attempts to repeal the health care reform act — health care reform is likely here to stay and physicians and hospitals will have to continue to stay focused on the issues as the health care reform debate continues at both the Ohio legislature and in Congress.

Dr. David urged members of the audience to talk to legislators about their concerns. She also noted that in this complex time when physicians cannot possibly know all there is to know about new developments in legislation and economics it is more important than ever to join and participate in organizations such as the AMCNO.



Members of the physician panel listen to the discussion on health care reform (l to r — Drs. Michael Nochomovitz, James Ulchaker, William Lewis, Matthew Frantz, and John Bastulli).

The AMCNO will be actively involved in developing solutions to the state budget crisis and the implementation of the federal health care reform legislation in Ohio. In addition, the AMCNO will continue our efforts to enact alternatives to the current tort reform system in Ohio as well as our efforts to implement health insurance reforms which would include spearheading legislation to transform the physician ranking programs utilized in Ohio.

The AMCNO has and will continue to offer opportunities for physician members to meet with area legislators. Watch for more information on our upcoming legislative meetings in 2011. ■

AMCNO Co-Sponsors Electronic Health Record (EHR) Session

(Continued from page 1)

and encouraged participants to join the organization. Dr. David also thanked both the Case REC and BHGC for collaborating with the AMCNO on the event and with projects in the Northern Ohio community that are of importance to physicians.

Dr. Cebul outlined the work of the BHGC noting that BHGC is a community-wide alliance that works to improve the care and outcomes of Northeast Ohioans with chronic conditions. He noted that by driving better outcomes and greater value for health care purchasers and consumers, BHGC strives to make the region healthier and a better place to do business. Dr. Cebul also outlined the results of the last BHGC "Community Health Check-up" as well as providing information on BHGC learning collaborative.

Ms. Costello and Mr. Peter provided background information on the services available through OHIP and the Case REC. The information provided in these presentations was similar to previous sessions hosted by the AMCNO.

The keynote speaker for the evening was Dr. Richard Baron. Dr. Baron has done consulting for the Robert Wood Johnson Foundation and the Center for Health Care Strategies on issues relating to Medicaid managed care and quality improvement, he also serves on the Standards Committee for NCQA, and he became a Board Member of the National Quality Forum in



Participants at the EHR event listen to Dr. Richard Baron's comments.

December 2009. Dr. Baron has had several articles published on the topic of electronic health records and meaningful use in the physician practice.

Dr. Baron commented on the increasing amount of work associated with practicing primary care noting that based upon studies done in his primary care practice a physician sees 18.1 patients a day. In addition to visits, however, 12.1 prescriptions are refilled, 31.5 laboratory panels or imaging reports are reviewed, and 23.7 phone calls are processed. Each of these activities demands ready access to information, however, because visits are all physicians get paid for they tend to regard everything else as a "hassle." Physicians need to recognize it for what it really is: modern medical practice.

He further noted that the problem many physicians are trying to solve with an EHR is the appropriate generation of a progress note — a document used to justify payment in a fee-for-service system. Physicians unfamiliar with EHRs tend to think of them as an electronic version of paper charts; however,

what physicians really need to be thinking about is structured data — the foundation for decision support, data exchange and reporting. Because patients do not usually provide their histories in a structured data format, EHR users have to translate what they hear or read into a format the system can use. Once a practice has structured data it can automate and support repetitive tasks such as prescription refills, enhance decision support aided by a team approach, track and trend patient care, identify and address care gaps, generate ongoing performance reports and conduct population management.

Dr. Baron stated that in his practice the EHR provides daily benefits for both patients and physicians. Because the EHR provides the practice with the opportunity to interact electronically with patients through a website, secure email and with laboratory results delivery. Patients in his practice can also view their medical chart through a secure site and email their physician with specific questions. The ability to share comprehensive information such as medication and problem lists with other physicians and consultants assists patients as they go to other settings for care outside of the primary care office.

Dr. Baron wrapped up his presentation by stating that most physicians are aware that the HITECH Act provides for incentives to be paid for attaining meaningful use. However, financial rewards for meaningful use should not be the only reason to adopt an EHR system — it is about using health information technology to improve patient care — it is about "being a better doctor." ■

The MedWorks Team Does it Again!

Thanks in large part to the medical volunteer team, MedWorks has once again hosted a successful medical clinic. Founded 16 months ago to help serve the medically disenfranchised, MedWorks most recently teamed up with a Cleveland-based Federally Qualified Health Center, NEON Health Services, Inc, to provide more than 2300 appointments and services to approximately 825 individuals across Northeast Ohio and beyond.

That represents a 15% increase in the number of services, as compared to the previous clinic held in May 2010. Not counting women's health, approximately 800 people received care by a primary care provider or specialist (including cardiologists, urologists, ENT specialists, podiatrists, rheumatologists, orthopedists, dermatologists, and others). The women's health department saw more than 300 women, compared to 180 at the previous clinic. Of those 300 women, 160 had pap tests and approximately 100 had mammograms as part of the clinic. Approximately 325 individuals had a dental appointment. More than 70 x-rays were performed and the laboratory conducted 260 blood and urine tests. Radiology and lab results were reported within 20 minutes and doctors had an opportunity to review findings with patients. Almost 200 people were HIV tested and now know their HIV status. Ninety-four people underwent hearing testing. More than 500 drug prescriptions were filled and individuals walked out with re-fill prescriptions, if indicated. For the first time, flu vaccines were offered and 275 people were vaccinated.

Each person at the clinic met with a social worker just prior to discharge to discuss clinic findings, answer questions, and begin to help patients connect with follow-up care. Representatives from hospital system and other community health center financial assistance programs met with clinic patients to begin discussing eligibility criteria for charity care programs. NEON made follow-up appointments for medical and dental care for more than 500 individuals who participated at the clinic. Those individuals will now have a place they can call their medical home.



Left to right – Drs. Tommaso Falcone, Laura David, Tia Melton and Diane Young spend a moment with two student nurses at the event.

The backbone of the program is the 1300 medical volunteers that are part of the MedWorks database. Of those, approximately 410 are physicians, 110 dentists, 170 dental assistants, hygienists and students; 70 optometrists and opticians; 80 social workers; 500 nurses, physicians' assistants, medical assistants and technicians; and 6 pharmacists.

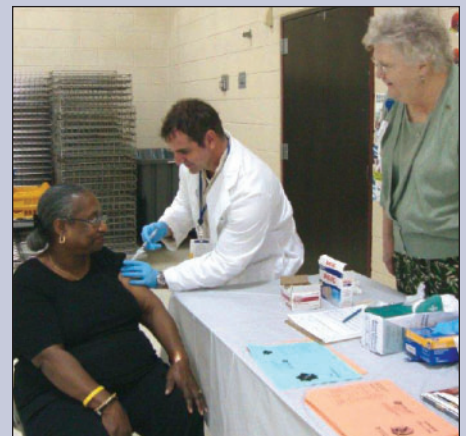
MedWorks considers The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) a great supporter and is grateful to partner with the organization. In addition to the countless AMCNO physician volunteers, MedWorks is extremely proud to have a special relationship with AMCNO's current president, Dr. Laura David. Dr. David serves on the MedWorks Board and heads the women's health operations. Under her guidance and dedication, approximately 600 women who may not have had recourse have been served! ■

AMCNO Hosts "Vote and Vaccinate" Program on Election Day

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) hosted its eleventh annual "Vote and Vaccinate" program on Election Day, Tuesday, November 2, 2010. The Vote and Vaccinate program offers pneumonia and influenza vaccinations to the public at voting locations across the region on Election Day. Vote and Vaccinate is a parallel program to the voting process and is not connected in any way with the Board of Elections.

The AMCNO was pleased to have participation again this year from our program sponsors: the Cuyahoga County Board of Health, the Cleveland Department of Health, Parma Community General Hospital and Saint Vincent Charity Hospital. The AMCNO expresses its sincere gratitude to site staff who participated in this worthwhile program at Parma South Presbyterian Church, Parma Heights Baptist Church, Ridgewood United Methodist Church, North Royalton United Methodist Church, Pilgrim Congregational United Church of Christ and Marion Sterling School.

The AMCNO plans to host this community event again in 2011. If your group or hospital is interested in participating with the AMCNO as a co-sponsor or host a site, please contact the AMCNO offices at (216) 520.1000.



A volunteer from St. Vincent Charity Hospital administers a flu vaccine to the assistant to Sr. Mary Ann Mozser, (far right) Vice President of Mission and Ministry at St. Vincent Charity.

To Do:

ATTENTION AMCNO MEMBERS

Is your listing accurate?

It's time again! Let us know of any changes to your listing for the forthcoming 2011-2012 edition of The Academy of Medicine of Cleveland & Northern Ohio's **Member Directory & Community Health Resource Guide**.

Report changes to the AMCNO office, (216) 520-1000, or fax, (216) 520-0999. **Deadline: April 15. Look for the new directory in late spring.**

Immunization Refusal: Communicating Effectively with Patients and Parents

By Diane A. Butler, M.D.

“MMR and Thimerosal causes autism”
 “Vaccines contain too many toxins”
 “I’ve never gotten the flu vaccine and I never get sick”
 “I have a friend who got the flu vaccine and got sick the next day”
 “I’d prefer my child have chicken pox”
 “I am not exposed to this disease”

How many of us have heard comments like these in our practice? Despite a > 99% success rate at decreasing morbidity for most of the vaccine preventable diseases within the past several decades, vaccine refusal is a common frustration for many pediatricians as well as those who routinely immunize adults. Although the benefits of influenza immunization have been well documented, adults as well as children remain unimmunized. Currently, about 90% of children receive most recommended vaccines and < 1% receive no immunizations, but rates are lower in children who live in poverty, and for adolescents and adults. In addition, geographic clustering of unimmunized children can lead to outbreaks such as the recent mumps outbreak in an eastern Cleveland suburb. Mumps is one of the diseases for which the annual baseline morbidity in the 20th century was 152,209 and, due to immunization, there has been a > 99% reduction in morbidity due to mumps, however, immunization refusal jeopardizes these successes. According to the California Department of Public Health, a recent pertussis epidemic in California resulted in 8 deaths due to the introduction of the infection into an under-immunized community. Also of note is a case-controlled study at Kaiser Permanente in Colorado, where 11% of pertussis cases were linked to vaccine refusal, which increased pertussis risk 23-fold.

In order to help educate patients and parents about the benefits of immunizations, it is necessary to know why vaccines are refused. The reasons given by parents for not immunizing their children are many (and vary by vaccine). Listed below are some of the reasons cited by patients for vaccine refusal and an example of how physicians may respond to these concerns:

1. Thinking that children are at low risk for the disease.
 - Explain that *this is true only so long as immunization rates are high, as recent outbreaks have proven.*
2. Knowing someone who was felt to have had an adverse reaction to a vaccine.
 - Explain the risks as well as the benefits of immunizations and also

that temporal association does not equal causation.

3. Feeling the risk of the vaccine was too great.
 - Explain that *the risk of the vaccine is much less than that of the disease.*
4. Preferring the child to acquire the disease (esp. for MMR and Varivax).
 - Explain that *chickenpox can kill and mumps can sterilize.*
5. Feeling that the vaccine was not effective.
 - Explain that *no vaccine is 100% effective, except Gardasil, and that even protection at less than 100% is of benefit.*

As physicians and nurses, we must be knowledgeable about concerns regarding vaccines and be able to answer questions that are raised. In some cases, the information is just a misunderstanding of the scientific data that has been published.

For example, recently a patient in my practice came in with a print out from a website that declared “Vaccine Pushed on Infants Causes Drug-Resistant Pneumonia: JAMA Study.” “The article concluded that “what is absolutely clear is that the vaccination scheme is not a carefully thought out program” but rather “the public is nothing but a vast testing lab with each and every person a potential lab rat.” This was in regard to the pneumococcal vaccine, Prevnar 7. Although it is true that there has been an increase in the incidence of resistant pneumococcal serotypes, especially 19A, since the introduction of Prevnar 7, the fact remains that the vaccine has saved hundreds of lives and serious illness by preventing disease due to the 7 vaccine serotypes included in Prevnar 7. In fact, within two years of the introduction of Prevnar 7, the 7 types in the vaccine almost disappeared and overall infection rates fell by 70%. And Prevnar 13 (which contains 19A) will provide even better coverage, although again encouraging a relative increase in non-vaccine serotypes. This type of information can be complex and difficult for patients to understand so physicians can help by putting such information into perspective.

Vaccine Concerns

There are at least 4 factors that contribute to “Vaccine Hesitancy.”

1. Risk-benefit perception
2. The power of the anecdote
3. The Internet – Pandora’s Box
4. Issues of trust

Parents and patients must realize that vaccine-preventable diseases are clearly still threats. So it is important to be knowledgeable about the mumps and pertussis outbreaks and the deaths caused by meningococcal meningitis and cervical cancer. However, vaccines are not 100% risk-free. Put these risks into context when talking to patients. Although fever, pain or redness at the injection site of a vaccine is common, severe adverse events are rare. Provide the appropriate VIS (Vaccine Information Statement) at each visit. For example, in my practice we provide the VIS at the prenatal or first newborn visit and also on our website for review prior to the immunization visit.

Because nearly 100% of children receive vaccines, immunization will appear to be temporally associated with ANY negative outcome that occurs in childhood. Parents need to understand that temporal association does not equal causation. Although anyone can report a concern about an adverse event following an immunization to VAERS (Vaccine Adverse Event Reporting System), think of this as a case series since there is no denominator and there is no way to separate temporality from causation in such reports. On the other hand, the Vaccine Safety Datalink (VSD) collects prospective data on 5.5 million individuals every year who are enrolled in 8 large managed care organizations, providing a true denominator that can be used to calculate the incidence of adverse reactions after immunization.

Approximately 74% of Americans report using the Internet daily and 16% have specifically searched online for information about immunizations. In addition, Blogs, YouTube and social media also contain a lot of information (as well as misinformation) about vaccine safety. Although the number of anti-vaccination sites is increasing, there are a considerable number of websites with useful, evidence-based information for medical professionals and patients. Interestingly, searching by “immunization” provides almost all pro-vaccine websites whereas searching by “vaccine” or “vaccination” provides mostly anti-vaccine websites. (See the list of recommended resources for communicating about immunizations at the end of this article.)

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Immunization Refusal: Communicating Effectively with Patients and Parents (Continued from page 5)

Remember that a trusting relationship with the primary care professional is the single most important element in helping a patient or parent to decide whether to become immunized. Emphasize that you and your family and employees have been immunized and that you would not recommend a vaccine that you wouldn't give to yourself or your own family members.

Vaccine Safety Myths

MMR and Autism

Although it took 12 years for Lancet to retract the paper published by Wakefield et. al. in 1998, despite being retracted by 10 of the 13 authors in 2004, the damage was done. Children whose parents were frightened enough by the widespread publication of this article and were denied measles vaccine, died as a result. There is no scientific evidence that MMR vaccine has any relationship to autism and current evidence supports a cause for autism which predates all immunizations with studies identifying signs of autism within the first months of life.

Thimerosal and Autism

Although information regarding the deleterious effects of mercury resulted in the voluntary removal of mercury from vaccines in 1999 (and a hold on the immunization of newborns with hepatitis B vaccine), the EPA guidelines which initiated the removal were for methyl mercury NOT ethyl mercury (which is what was used in immunizations as a preservative). In the meantime, a least one infant died of fulminant liver failure due to hepatitis caused by the lack of receipt of the newborn hepatitis B immunization. Despite attempts to make an association between thimerosal and autism, the fact remains that rates of autism have continued to increase despite removal of thimerosal from routine childhood vaccines. The only vaccines that still contain thimerosal are the multidose vials of influenza vaccine.

Too many vaccines, too soon.

Despite contentions to the contrary, there is no evidence that delaying childhood immunizations has any protective effect whatsoever. A recent study in *Pediatrics* found that children who received all vaccines on time in the first year of life had similar or better neuropsychological outcomes than those with delayed receipt or non-receipt of vaccines. In addition, the current vaccine schedule, although including many more vaccines, actually provides about 10% of the number of antigens given decades ago. Unfortunately, it has been my personal experience that there is no standard "alternative

immunization schedule" requested by parents for their children. As a result, irregular schedules increase the risk of giving immunizations at inappropriate intervals and of missing certain immunizations completely. Such schedules result in increased office visits and increased infant stress from immunizations. Despite these difficulties and the inherent risk of having under-immunized children in the office, the American Academy of Pediatrics (AAP) does not recommend excluding such children from your practice. Although I personally do not agree with parents' decisions to delay or refuse immunizations, allowing them to return for visits provides repeated opportunities for continued discussions about the importance of immunizations and I have found that many patients do eventually receive most of their immunizations, albeit on a delayed schedule.

Suggested Communication Strategies

1. Discuss concerns and attitudes about immunizations, including cultural, religious or personal beliefs.
2. Assess the patient and parents' knowledge about risks and benefits of immunizations. Listen to parental and/or patient concerns first and answer their questions with respect, not defensiveness.
3. Educate in an individualized manner using your knowledge of the patient or family.
4. Present the benefits of immunization for both the individual and the community.
5. Address adverse affects (provide the VIS) and how to minimize the stress of shots.
6. Remain flexible in your administration of immunizations even if it means a less than complete schedule.

How to increase immunization acceptance

1. Overcome barriers to receipt of immunizations
 - a. Immunize at every possible visit (avoid "missed opportunities" to provide immunizations at visits for injuries, mild illness, etc.)
 - b. Provide immunization "clinics" that are in the evening or after routine office hours to accommodate working parents and teens' schedules.
 - c. Encourage annual well visits for teens.
 - d. Offer techniques for making immunization less painful (distraction, vapocoolant sprays, topical lidocaine cream, etc.)
 - e. Allow quick "nurse visits" to give immunizations without waiting for a routine examination.

- f. Become a VFC provider so that your Medicaid patients can receive their immunizations at your office. (These vaccines cannot be used for patients 19 years old or older.)
- g. Use automated systems to provide reminders for immunization visits.
- h. Schedule subsequent appointment dates at the time of the first immunization for vaccines that are given in a series (e.g., hepatitis A and Gardasil). We explain that we realize that a patient may not know their schedule so far in advance but that we will call to remind them of the visit 2 days in advance and if there is a conflict, the appointment can be rescheduled, but at least it won't be forgotten.
- i. Give written reminders of future dates of immunizations and try to combine immunizations with other appointment dates.
- j. Allow adolescents to come in for immunizations without their parents' having to be present (with appropriate release by the parent).
- k. Advocate for coverage of immunizations by insurance companies.

2. Educate parents and patients about the need for immunizations.

- a. Provide appropriate VIS at each visit, starting at the prenatal and newborn visit for pediatric patients, even when the immunization is refused.
- b. Inquire about current concerns regarding immunizations and explain misconceptions.
- c. Offer handouts with websites about the safety and importance of immunizations. (see websites at the end of this article).
- d. Provide information and web links on your practice's website.
- e. Remind families of school-based immunization requirements, the most recent being the need for Tdap prior to 7th grade in Ohio.
- f. Support the immunization recommendations of your professional organizations (AAP, Academy of Family Practice (AFP), etc.).
- g. Explain how diseases can be introduced via international travel so that even though the patient may not travel the world, "the world travels to us."
- h. Remind parents (or patients) who refuse immunizations to inform any health care professional with whom they (or their under-immunized child) comes into contact, of their immunization status and be aware that this information may result in

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procedures that would not otherwise have to be performed (such as blood work, spinal taps, prophylactic antibiotics for the patient and contacts, etc.) I also caution parents that many physicians have never seen polio, measles, mumps, pertussis (whooping cough) and epiglottitis from H. influenza due to the effectiveness of the current immunizations and may not quickly recognize these diseases in their child.

- i. Require that parents sign the AAP's form for immunization refusal each time a required immunization is refused.
3. Be aware of contraindications for specific immunizations, guidelines for the administration of multiple vaccines and delayed immunizations and specific cautions to be taken for the adolescent immunizations.
 - a. In general, all vaccines can be given concomitantly.
 - b. Vaccines with a lapse in completion do not need to be "restarted."
 - c. Live vaccines that are not given together (MMR, Varivax, FluMist) must be given at least 28 days apart.
 - d. Certain vaccines need to be started by a certain age and/or completed by a certain age (e.g., rotaviral vaccines must be started prior to 14 weeks 6 days and completed by 8 months 0 days, Tdap cannot be given prior to 10 (Boostrix) or 11 (Adacel) years of age and Gardasil is only licensed for use between 9 and 26 years.)
 - d. Have a copy of the Centers for Disease Control's (CDC) Recommended Immunization Schedule that lists the immunization schedule for primary immunizations and for catch-up immunizations so that errors are not made in the provision of immunizations, especially for those on an "alternative" schedule.
 - e. Be aware of the current recommendations that adolescents should remain in the office for 15 minutes after receiving their immunizations since some (especially Gardasil, but others as well) have had syncope described after receipt. As a result of this recommendation and the inconvenience it may cause to some families, we have started offering to give these immunizations at the beginning of the office visit, allowing the adolescent to be under constant supervision during the patient interview and examination and eliminating the need to stay after the examination.

4. Motivate your staff to become advocates for immunizations
 - a. Increase awareness of adolescent immunizations with staff meetings or webinars.
 - b. Share practice goals and HEDIS compliance data.
 - c. Utilize training programs sponsored by the CDC, AAP, etc.
 - d. Review charts to identify physicians and other staff who may need additional education to improve their immunization rates.
 - e. Recognize staff who achieve immunization goals.
 - f. Participate in immunization registries. My practice was involved in the creation of Ohio's immunization registry and all our patients' immunizations are entered into the registry for others to access.
 - g. Encourage all of your own staff to be fully immunized.
5. Evaluate the success of your immunization efforts
 - a. Determine your practice's influenza and adolescent immunization rates. (Practices tend to overestimate their immunization rates.)

- b. Participate in VFC's immunization tracking program, AFIX (Assessment, Feedback, Incentives, Exchange).

As physicians we know the benefit of immunization and it is important that we continue to communicate with parents and patients about these benefits. Listed below are several references as well as websites that are recommended for providing communication to your patients about immunizations.

In addition to familiarizing yourself with the content of the sites noted in this article, consider assigning a clinician (physician or nurse) to regularly monitor the sites you find most useful for new information and updates.

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. ■

References and Resources:

1. The American Academy of Pediatrics has advice for communicating with families, resources for vaccine conversations, vaccine safety information and materials developed for physicians to provide to families (useful for non-pediatricians as well). www.aap.org/immunization/pediatricians/communicating.html (AAP's main immunization site is www.cispimmunize.org.) American Academy of Pediatrics Committee on Infectious Diseases. 2009 *Red Book*.
2. The Centers for Disease Control and Prevention's health care provider immunization page contains provider resources for conversations with parents regarding vaccine concerns, including answers to parents' frequently asked questions, examples of responses to questions about vaccine safety including autism, risk of vaccine versus risk of disease, number of vaccines and vaccine ingredients, vaccine side effects, recommendations and resources for when parents refuse to vaccinate, and more (Click on the link for provider resources for conversations with parents). www.cdc.gov/vaccines/hcp.htm Recommended Immunization Schedule for Persons Aged 0-18 Years <http://www.cdc.gov/vaccines/recs/acip> CDC. MMWR. 2010;59(5):133-135. CDC. Assessment, Feedback, Incentives, and Exchange (AFIX). <http://www.cdc.gov/nip/afix>
3. National Network for Immunization Information (NNii) offers up-to-date, reliable information and resources for physicians and parents on vaccine science (safety, misconceptions and vaccine preventable diseases) and vaccine news that is useful in communicating with both parents and adult patients. NNii does not accept any financial support from the pharmaceutical industry or the federal government. www.immunizationinfor.org
4. Children's Hospital of Philadelphia Vaccine Education Center, led by Director Paul Offit, MD, has resources and educational materials related to childhood and adult immunization, including a vaccine safety, for parents and health care professionals. The center is funded by endowed chairs from Children's Hospital of Philadelphia and foundation grants and does not receive support from vaccine manufacturers. www.chop.edu/service/vaccine-education-center/home.html
5. The Immunization Action Coalition provides a large variety of useful information for health care professionals, including vaccine safety information, books, other publications and links to additional resources. www.immunize.org
6. The Healthy People 2010 Committee of the Ohio Chapter of the American Academy of Pediatrics has developed three new brochures addressing the issue of parental refusal of vaccines. To view the brochures go to <http://www.ohioaap.org/>



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AMCNO Legislative Update

By Connor Patton, AMCNO Lobbyist

November 2, 2010 was a truly historic day in Ohio. Republicans won all five statewide constitutional offices led by Governor-elect John Kasich (R). They picked up two State Senate seats (taking the GOP majority in the upper chamber to 23-10) and resoundingly took back the Ohio House of Representatives.

While the winds of change blew through Ohio at tornado-like speed, the lasting impact of this election will be felt for years to come. The Ohio Apportionment Board, which consists of the Governor, Secretary of State and Auditor of State, draws the legislative boundaries for the Ohio General Assembly and U.S. Congressional districts. These districts must be drawn in 2011 (based on the 2010 Census report). With Republicans sweeping the statewide offices, the apportionment board will likely draw state House and Senate districts and the General Assembly will draw congressional districts that significantly benefit Republican candidates, making a Republican majority the likely political environment in Ohio for the next decade.

On the federal side, Republicans have regained control of the U.S. House of Representatives, and Ohio Congressman John Boehner (R) is the next Speaker of the House. Ohio will send five new members to the House of Representatives, and one - Rob Portman (R) - to the Senate, all of whom are Republicans. The Ohio Congressional delegation will consist of 14 Republicans and six Democrats come January.

Two of the most critical races in Ohio for physicians and for the members of the AMCNO were those of Justice Maureen O'Connor (R) and Justice Judith Lanzinger (R). Both of these Justices have records of maintaining a philosophy of judicial restraint and both Justices have voted to uphold certain tort reforms. Due in large part to support from the AMCNO and the physician community, NOMPAC-endorsed candidate Justice Maureen O'Connor (R) was elected as the first female Chief Justice of the Ohio Supreme Court and Justice Judith Lanzinger (R) was re-elected to the Court.

In Northeast Ohio the Republican Party made significant gains and as a result we will have new leadership from our region in Columbus. In addition to the new Chief Justice of the Ohio Supreme Court Maureen O'Connor, who is a former Summit County Prosecutor and currently resides in Cleveland, State Representative Bill Batchelder (R) of Medina will be the new Speaker of the Ohio House of Representatives replacing Armond Budish (D) of Beachwood. Josh Mandel (R) of Lyndhurst has been elected to serve as the new State Treasurer and State Auditor Mary Taylor (R) from Summit County will move over to Lieutenant Governor.

Northeast Ohio also picked up a number of new Republican seats in the Ohio House and Ohio Senate. In the Ohio House, Republican Mike Dovilla (R) of Berea defeated State Representative Matt Patten (D) for the 18th House District and Marlene Anielski (R) of Walton Hills was elected to replace Josh Mandel (R) in the 17th House District. In Summit County, House Democrats lost 3 seats when Mike Moran (D) of Hudson, Brian Williams (D) of Akron, and Steve Dyer (D) of Green all lost. They will be replaced by Kristina Roegner (R) of Hudson, Lynn Slaby (R) of Copley, and Brian McKenney (R) of Akron. In Lake County Ron Young (R) defeated Mark Schneider (D) and Tim Grendell (R) was elected to replace Matt Dolan (R). Grendell has chosen not to take the job and remain in the Ohio Senate - at press time it was not clear who would be appointed to fill the seat in the Ohio House. In Ashtabula, another Republican, Casey Kozlowski (R), was chosen to replace State Representative Debbie Newcomb (D).

Democrats now have 3 new members from Cuyahoga County in the Ohio General Assembly - Bill Patmon (D) and John Barnes (D) of Cleveland, and Nickie Antonio (D) from Lakewood. In addition, Mike Skindell (D) also from Lakewood will replace Dale Miller (D) in the Ohio Senate. In Lorain County, Dan Ramos (D) has been chosen to replace Joe Koziura (D) and Gayle Manning (R) defeated Sue Morano (D) for the Ohio Senate. Last, Frank LaRose (R) of Fairlawn was chosen to replace State Senator Kevin Coughlin (R). AMCNO plans to reach out and meet with the newly elected members as soon as possible.

Budget Issues for Ohio

With a projected \$8 billion dollar budget gap predicted in Ohio, massive change will need to occur. It could come in the form of tax increases, reorganization of government, and budget cuts. And when budget cuts are on the table, the two biggest targets are Medicaid and education due to the fact that these two items make up over 70% of the \$50 billion state operating budget. In addition, there may be strong consideration of how funding is provided to nursing care facilities and funding being shifted to more cost efficient types of care.

A budget review commission met this fall and came up with some recommendations to address possible budget shortfalls in the next state operating budget. Medicaid will be the number

one place Governor Kasich and the legislature will look to make cuts. Some of the recommendations and items under discussion are as follows:

• Medicaid Reforms

Opt out of Medicaid? - It has been made fairly clear that Ohio should NOT opt out of the Medicaid program since this could result in the loss of the assumed 64-cent federal draw down for each dollar spent. This would significantly reduce Ohio's medical service purchasing ability and would have a severe negative effect on both recipients and providers. The state should carefully watch developments across the country with regards to states opting out, though. As of late November 2010, Washington, Texas, South Carolina, Wyoming, and Nevada officials have publicly discussed opting out. The federal government could enact significant changes or even repeal the 7 unfunded or underfunded portions of health reform if state governments articulately express their cost concerns.

Managed Care Expansion - Enrolling more of the existing caseload into a managed care setting could improve health outcomes and reduce costs for the program.

Re-aligning Ohio's Long-Term Care Spending - As testimony before the Budget Management and Planning Commission (BMPC) detailed, Ohio's spending on long-term care is not aligned with national spending trends. As consumers demand different options and providers change delivery models to reduce costs while improving care, our Medicaid system must change as well. An evaluation and modernization of how Ohio pays for long-term care services should be pursued, while ensuring a quality continuum of care.

Block Grant - Ohio should review those states which have applied for block grant Medicaid funding rather than the traditional match methodology. The flexibility is desirable, but it must be weighed against the longer-term spending reductions that are necessary in block grant scenarios. Generally, block granting results in capped funding (much like when Temporary Assistance for Needy Families (TANF) was implemented).

Seek Federal Reimbursement for Prisoner In-Patient Health Services - The state and local political subdivisions pay the medical expenses of Ohio's incarcerated population. For Medicaid eligible populations, this could be a significant cost-savings for both the state and local governments.

Review Ohio Commission to Reform Medicaid Report - Reviewing recommendations of this report that was released at the end of 2004 would be very worthwhile. To view the report go to <http://ohiomedicaidreform.gov/>.

(Continued on page 10)

LEGISLATIVE ACTIVITIES

AMCNO Legislative Update

(Continued from page 9)

• Federal Assistance

Medicaid funding – The recently enacted federal health care law will significantly increase Ohio's costs. Even with the federal government planning to pay for newly eligible people, the Ohio Department of Job and Family Services estimated in April that 279,000 of the 554,000 new enrollees are currently eligible people that the state will need to cover. The federal government should pick up the costs for any enrollee who signs up for Medicaid due to the passage of the health reform act.

Medicaid relief – If the so-called enhanced FMAP funding is not continued, the federal government should grant states the ability to limit eligibility to levels lower than those mandated by the health reform act.

Unemployment Compensation fund – Ohio's negative balance exceeds \$2.3 billion. The Office of Budget and Management estimated that the interest alone on this borrowing may cost the state over \$290 million in the 12-13 biennium. Congress should be asked to extend the waiver of interest payments.

Ensure maximization of federal match – For all programs run by the state that draw a federal match, Ohio must ensure that every dollar it expends that is eligible for match is being matched.

AMCNO Advocacy

With Medicaid making up nearly one-third of Ohio's budget, the AMCNO will work with the new Ohio legislature in an effort to ensure that cuts to physicians' Medicaid reimbursement rates do not occur, although this may be difficult to achieve since the Republicans have indicated that they do not want to raise taxes or increase the size of government. The

AMCNO lobbyists will be integrally involved in not only the Medicaid portion of the budget debate but in all other aspects of the discussion to assure that any items related to health care are brought to the attention of the AMCNO. With so much change in government, it will be important for the AMCNO to develop a strategy on how to effectively navigate through this new environment.

The AMCNO's Physician Ranking bills - HB 122 and SB 98 did not make it through the legislature, but made great strides and brought a lot of awareness to the issue. Getting the physician ranking bills through the Ohio House of Representatives was quite an achievement and a lot of time and energy was dedicated to this initiative. AMCNO carried this issue farther than any other interest group in a very difficult and tumultuous political climate. Groups that AMCNO met with and lobbied included the Ohio Attorney General, Ohio State Medical Board, Ohio Department of Insurance, Ohio House of Representatives, and the Ohio Senate. State Representative Barbara Boyd deserves many thanks for her dedication to this issue and for working very hard to convince nearly all the members of the Ohio House of Representatives of its importance.

Unfortunately, the General Assembly left very early for the summer and as a result of the election outcome this fall, the Ohio Senate and Ohio House could not come to an agreement on concluding the 128th General Assembly with a lame duck session. Any legislation that had not been enacted died at the end of 2010 and will have to be reintroduced in the next General Assembly which begins on January 3, 2011.

Also, the Ohio Prescription Drug Abuse Task Force finished convening and produced its recommendations. The Task Force was created to address what has been perceived as a national epidemic occurring in impoverished

rural and urban areas. The recommendations will be implemented by agencies and legislation will also be introduced in the next Ohio General Assembly to address issues that need to be changed by statute. The AMCNO intends to be an integral part of the discussion as the work of this task force continues in 2011.

At the federal level, concern continues with regard to the constant threat of Medicare payment cuts. At press time, Congress had passed legislation known as the "Medicare and Medicaid Extenders Act of 2010," which will stabilize Medicare physician payments at current rates for 12 months—through the end of 2011—and stop the 25 percent cut that was originally scheduled to take effect on Jan. 1. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has written to Congress on numerous occasions regarding the need to permanently replace the Sustainable Growth Rate (SGR) formula once and for all. 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.

The AMCNO legislative committee and our physician leadership will be meeting with many of the newly elected representatives and the new Senate and House leadership in the coming months. The legislative committee also monitors and reviews all healthcare related legislation introduced by the Ohio legislature and provides updates and background on key legislation to our members. For more information on the AMCNO legislative activities please contact the AMCNO offices at 216-520-1000. ■

NORTHERN OHIO PHYSICIAN

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THE NORTHERN OHIO PHYSICIAN (ISSN# 1935-6293) is published bi-monthly by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Periodicals postage paid at Cleveland, Ohio. POSTMASTER: Send address changes to NORTHERN OHIO PHYSICIAN, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Editorial Offices: AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131, phone (216) 520-1000. \$36 per year. Circulation: 3,500.

Opinions expressed by authors are their own, and not necessarily those of the Northern Ohio Physician or The Academy of Medicine of Cleveland & Northern Ohio. Northern Ohio Physician reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.

ADVERTISING:

Commemorative Publishing Company c/o Mr. Chris Allen, 3901 W. 224th Street, Fairview Park, OH 44126
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On Election Day, the AMCNO had physicians at polling sites to provide information to the voters on the importance to physicians of the Ohio Supreme Court judicial races. Pictured at left at a polling site in Shaker Heights is **Dr. Paul Janicki**, AMCNO Past President.

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AMCNO President Discusses Health Care Reform

In November, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) President, **Dr. Laura David**, provided a presentation to the Cleveland Society of Obstetricians and Gynecologists on the topic of "Health Care Reform: Where we Started, Where We're Going." Ms. Cathy Costello, JD, the Ohio Health Information Partnership (OHIP) Project Manager for REC services also provided a detailed overview of OHIP and the meaningful use incentives.

The objectives of Dr. David's presentation were to identify the forces shaping health care reform, to review the current expectations for patient coverage and physician involvement, to anticipate possible adaptations in office practice and to learn approaches for reaching meaningful use with electronic health records. Dr. David outlined the fact that health care costs and health care spending in the United States is due to many factors such as the costs for Medicare, Medicaid, extremes of care, preventable diseases and complications, administrative costs, prescription drug costs and value decisions. For example, she noted that Medicare costs are predicted to reach over \$900 billion by 2040 — or 7% of the GDP. Medicaid spending is predicted to rise as well. Extremes of care that are costly include the fact that over 27% of Medicare spending occurs in the last 12 months of life. With

regard to preventable diseases and complications, she noted that over 50% of all health care costs in the United States are due to obesity, diabetes management, high blood pressure, smoking and chronic lung disease, alcohol and drug consumption. She also noted that over 80% of costs are consumed by only 20% of the population.

Dr. David also provided the group with an overview of the Affordable Health Care Act and how the Act could impact the practice of obstetrics and gynecology. She noted that the penalties included in the Act were minimal for those citizens that had to pay a tax penalty for lack of health care coverage. The Act also includes costs controls and reviews such as the establishment of an Independent Payment (Medicare) Advisory Board of 15 members, non-MDs, for 6-year



Physician attendees at the OB/GYN Society event listen to **Dr. David's** presentation on health care reform.

terms; with the Department of Health and Human Services directing Value-Based payment modifiers and establishing a Physician Compare website.

Dr. David concluded by stating that health care reform had some benefits for physicians, but there are also some inherent problems that need to be addressed in the future such as the repeal of the sustainable growth rate (SGR) Medicare physician payment formula, and adding meaningful liability reform at the federal level. ■

AMCNO Board Members Discuss the Health Information Technology Grant Advisory Program

Mr. Lawrence Voyten, program manager and director of the Health Information Technology department at Tri-C was in attendance at the November AMCNO board of directors meeting to talk to the AMCNO physician leadership about the \$14 million health information technology grant Tri-C has received as part of the stimulus dollars in order to train a workforce for the implementation of electronic health records.

He noted that the Office of the National Coordinator has made this money available to community colleges around the country to train individuals to assist with the roll out of electronic health records and meaningful use. Tri-C has enough grant money to train 760 individuals in Northeast Ohio to be clinical specialists — or trainers/managers in this area. They currently have 43 students enrolled and they plan to launch the remainder by first quarter of 2011. He is currently in the process of hiring additional faculty to support the program and the first graduates will complete the program by mid-January 2011. The regional extension centers as well as electronic health record vendors have already expressed an interest in hiring these students upon graduation in order to utilize their skills to support community physicians in making the transition to electronic health records.

In order to get into the program applicants have to possess either a health care or information technology background. The curriculum is in an e-learning environment with some additional face-to-face classes working with applications and coordinators, and the program takes twenty weeks to complete. The intent of the program is to train individuals to transition into the health information exchange world — with graduates having the ability to work on applications, implementation and other aspects of EHR. These individuals will be support specialists that will be mobile that will go out to the physician practice sites and assist the practice as well as providing support or a "help desk" activity after the EHR implementation has occurred.

The AMCNO board asked if there were avenues where the AMCNO could be of assistance with the Tri-C program. Mr. Voyten outlined multiple levels where the AMCNO could connect with the program such as letting physicians in the community know that the program exists and that these individuals will be able to assist them in the future. In addition Tri-C is currently looking for active faculty to assist with the program — individuals that have experience in this field. Last, Mr. Voyten noted that if there are physician practices out in the community that have an individual in their practice that has either a health care or information technology background they may want to consider having that person apply for this program.

The AMCNO has a physician representative on the health information advisory committee working with Mr. Voyten on this program. Over the next few weeks there will be press releases sent out outlining the program as well. Mr. Voyten would be happy to connect with the AMCNO or our members at any time regarding the program as it moves forward. To learn more, call (216) 987-2723, or email HITGrant@Tri-C.edu. ■

Cuyahoga Health Access Partnership (CHAP) Highlighted at the American Public Health Association (APHA) Annual Meeting

The Cuyahoga Health Access Partnership (CHAP) was pleased to participate in the 138th Annual Meeting and Exposition of the American Public Health Association (APHA) where more than 12,000 public health professionals from around the world met to address the nation's top public health challenges.

The APHA Annual Meeting provides a unique platform for thousands of public health professionals to come together to share the latest research, discuss advocacy efforts, build new partnerships and address emerging health issues currently facing the nation. Themed "Social Justice: A Public Health Imperative," the meeting provided a forum to address a broad range of significant public health issues, including health reform implementation, health disparities, climate change and health, and emergency preparedness.

The CHAP partners were honored that our project was asked to send a presenter to this prestigious national forum. Ms. Kate Nagel, the CHAP board chair, provided the presentation at APHA during the Access to Care session. The following is a brief overview of the points Ms. Nagel covered at the event.

CHAP Organization and Vision

Ms. Nagel began by providing background on CHAP stating that it is a joint-public-private partnership focused on access to care for the uninsured in Cuyahoga County and was founded on the principle of shared responsibility of all healthcare organizations to face the uninsured crisis. She provided information on the partners participating in the project, which includes safety net providers, major hospital systems, government entities, health plans, foundations and other relevant organizations. *(For a list of all participating partners please see the end of this article.)*

She further explained how diverse stakeholders are committed to expanding access to care through a county-wide access program with the intent to provide a user-friendly system of health access to replace the current state of fragmentation for the county's uninsured adults.

Goals

CHAP's vision is to provide a system of access for uninsured adults in Cuyahoga County. While CHAP focuses on the importance of primary care, its efforts will extend throughout the entire spectrum of care. This would include standardized financial eligibility screening and the development of a web database for CHAP members — with the intent to identify a primary care home for members and facilitate referrals to specialty care.

Immediate Community Benefits

CHAP plans to standardize the enrollment and eligibility process across the provider network for patients at or below 200% of the federal poverty level; develop continuity of care across the primary and specialty care provider networks, and reduce reliance on episodic emergency department visits in favor of primary care homes for acute, non-life-threatening and chronic problems.

Accomplishments and Challenges

Ms. Nagel provided insight on some of the project's accomplishments to date which include a contract to purchase customized web-based financial eligibility software as well as the development of a provider directory tool modeled on insurance provider networks. She also noted some of the challenges which include differences among stakeholders in their FPL calculation, as well as differences in information technology capabilities. In addition, the program design has to ensure that neither financial hardship nor administrative burden falls disproportionately on certain organizations (e.g. hospital vs. non-hospital organizations, organizations with advanced IT systems vs. those without).

Long-term Benefits

Ms. Nagel informed the audience that CHAP plans to promote continuity of care by establishing a primary care home for participants in order to manage chronic disease more effectively with the intent to improve health outcomes. Other benefits include the increased screening of the adult uninsured population to identify eligibility for existing insurance programs as well as the intent to reduce episodic care and duplicative financial evaluations, thereby lowering the financial/administrative burden of uncompensated care for provider organizations. This partnership will also create a shared model of accountability and responsibility across the Cuyahoga County health provider community.

Future Plans

In closing, Ms. Nagel outlined some future plans for CHAP such as the improvement in primary care through advancing the patient-centered medical home model, improvement in quality data collection and dissemination, the use of CHAP utilization data to direct expansion of primary care capacity and the recruitment of private practice providers to treat uninsured patients.

Timeline for CHAP

CHAP is using a phased

approach to operationalize the enrollment, to work through coordination, cooperation and referral patterns so it is seamless for the client. First clients are to be enrolled starting December 1, 2010.

CHAP Partners

The Academy of Medicine of Cleveland & Northern Ohio
Care Alliance Health Center
CareSource
City of Cleveland
Cleveland Clinic
Cuyahoga County
Kaiser Permanente
MetroHealth System
Neighborhood Family Practice
Northeast Ohio Neighborhood Health Services
North Coast Health Ministry
Saint Luke's Foundation
Sisters of Charity Health System
The Free Medical Clinic of Greater Cleveland
University Hospitals

The AMCNO has been integrally involved in the planning and implementation of CHAP and we continue to collaborate with the CHAP partners. AMCNO members may be contacted in the future to ascertain their level of interest in CHAP participation. ■

Roth IRA Conversion..... Is it Right for You?

The Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA) eliminates income limits and allows all taxpayers to convert traditional IRAs to Roth IRAs beginning in 2010.

Roth IRAs can play an important role in retirement and legacy planning as they allow for tax-free growth and withdrawals that are not subject to required minimum distributions during the account owner's lifetime. If you have questions and wonder whether or not a conversion is right for you, we can help. Take advantage of the AMCNO member discount for a complimentary Roth conversion consultation.

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Solving The Third Party Payor Puzzle Seminar Provides Key Information

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to host its twenty-sixth annual "Solving the Third Party Payor Puzzle" seminar on Wednesday, November 17. The following insurance companies participated in the event: Medical Mutual of Ohio, CIGNA Healthcare of Ohio, Palmetto GBA, the Ohio Department of Job and Family Services (ODJFS), UnitedHealthcare, Anthem Blue Cross and Blue Shield and Availity, LLC. The seminar was moderated by the AMCNO Executive Vice President/CEO and President **Dr. Laura J. David**.

All presenters noted that staying abreast of current solutions is vital for health care administrative professionals to meet the future needs of the conversion of electronic claims. Presenters encouraged guests to utilize available electronic tools to streamline practitioners' needs.



Andrea Caesar (left) from the Ohio Department of Job and Family Services spends a moment with Vanessa Williams from PalmettoGBA.

Medical Mutual of Ohio walked through the process of utilizing their ePortal. The portal includes their Treatment Cost Estimator (TCE), which provides immediate results to automatically pay and provide the status of a "real time" claim. The system eliminates the need for faxed and paper claims. "Network access accounts are like gold." — Diana Irvin/Medical Mutual of Ohio.

An update on eServices and Electronic Remittance Advice (ERA), was provided by CIGNA Healthcare of Ohio. Their Cost of Care Estimator provides information on responsibility for payment and an estimate. MYCIGNA.com is a tool for physicians and medical staff, to open up communication between the patient and health care provider.

In addition, CIGNA and Surescripts have partnered to provide electronic prescriptions

to the patient's pharmacy by the time they leave the physician's parking lot. Wellness programs offered by CIGNA include smoking cessation, stress management and weight loss control. "We are not changing the way we work, we are making it easier." — Sonja Magnani/CIGNA.

Palmetto GBA Medicare Part B reviewed the Physician Quality Reporting (PQRI) program and their electronic feedback reports. An update on the current Health Information Technology (HITECH) was also discussed noting how Eligible Professionals (EPs) can receive a maximum of \$44,000 incentive payment through 2014.

Ms. Williams noted that the ANSI Version 5010 is essential for the use of ICD-10-CM and testing begins on January 1, 2011. Compliance is expected by January 1, 2012. This will include 5010 HIPAA Implementation Guides and 2011 Medicare Par Enrollment and Fee Schedule Information. Providers with an EDI enrollment agreement are encouraged to utilize Online Provider Services (OPS) free of charge. "Stay connected to your contacts and resources." — Vanessa Williams/Palmetto GBA Medicare Part B

A presenter from the Ohio Department of Job and Family Services provided updates on the Medical Information Technology System (MITS) and the registration for the Electronic Funds Transfer in lieu of paper.

Although the implementation of MITS has now been delayed, once implemented, this system will provide online claim submission, new remittance advices and a clinical claims editor.

Annie Boynton from UnitedHealthcare, urged providers to migrate to 5010 / ICD-10 by January 1, 2012 as it will go live by October 1, 2013. Provider interpretation

consistency will result in improved practice revenue. "We cannot get to the EHR environment without ICD 10," noted Ms. Boynton. The three main areas impacted include: medical management, contracting and fraud and abuse. UnitedHealthcare is committed to full regulatory compliance and has requested America's Health Insurance Plan (AHIP) to take action regarding crosswalk, training, communication and implementation dates.

Presenters from Anthem Blue Cross and Blue Shield shared how their Care Comparison pricing is bundled into one rate package. Anthem lines of business for members include local and Medicare advantage (FACETS), Bluecard (WGS), national (NASCO) and federal employees. Adjudication and timing of claims is tracked and reviewed for quality consistency. "Care Comparison pricing takes the guess work out of health care decision making for the patient." — Scott Snyder/Anthem Blue Cross and Blue Shield.



Practice administrators from around the region received valuable information from the insurance company representatives presenting at the session.

The seminar wrapped up with Availity, LLC incorporating an on line presentation of their user friendly website for providers to obtain cost and time savings through Availity's services.

Questions were shared by guests and presenters offered key information regarding the benefits of utilizing electronics to improve the work flow of claims and future health care compliance issues. Watch for information on the Third Party Payor seminar in 2011. ■

Organized Medicine Successful in Clarifying the Red Flags Rule

The U.S. House of Representatives has passed S. 3987, the "Red Flag Program Clarification Act of 2010" — legislation that limits the type of creditor that must comply with the "red flags" rule. Because the U.S. Senate unanimously passed the bill on Nov. 30, it is being sent to the White House where President Obama was expected to sign it into law before the Jan. 1, 2011, deadline.

The red flags rule, originally scheduled to take effect Nov. 1, 2008, requires creditors to develop identity theft prevention and detection programs. According to the Federal Trade Commission (FTC), physicians who do not accept payment from their patients at the time of service are creditors and must comply with the rule by developing and implementing written identity theft prevention and detection programs in their practices.

Many medical associations, including the AMCNO, wrote to Congress asking that physicians be removed from the scope of the red flag rules. In addition, the American Medical Association (AMA) worked with the FTC and Congress and is engaged in a lawsuit with other physician groups to get the FTC to permanently remove physicians from the scope of the red flags rule. There have already been five delays of the red flags rule implementation date due to the concerns of organized medicine. This legislation supports the argument that physicians are not creditors and it is hoped that the FTC will now acknowledge that the red flags rule should not apply to physicians.

Ohio Medicaid Delays Implementation of MITS

Ohio Medicaid has delayed the implementation of its newly developed Medical Information Technology System (MITS) for claims processing, provider enrollment, and prior authorizations. The new system was scheduled to go live on December 7th 2010; however, due to issues with the implementation process, Ohio Medicaid delayed the go live date to a time yet to be determined. Although there is a delay in implementation it is still important for you and your staff to sign up to use the MITS system in order to become familiar with the new format and functionality of the system to avoid any disruptions in Medicaid reimbursement down the line.

One-year Medicare Payment Cut Reprieve

Congress has passed legislation known as the "Medicare and Medicaid Extenders Act of 2010," which will stabilize Medicare physician payments at current rates for 12 months — through the end of 2011 — and stop the 25 percent cut that was originally scheduled to take effect on Jan. 1. In addition to providing a 12-month reprieve from the Medicare physician payment cuts being produced by the sustainable growth rate (SGR) formula, the bill extends a number of other payment policies through 2011 that were originally set to expire at the end of this year, including: the "floor" on geographic adjustments made for the physician work component of the Medicare payment schedule; the 5 percent payment increase for certain Medicare mental health services; payments for the technical component for certain pathology services; and the exceptions process for the cap on Medicare outpatient therapy services. The AMCNO will continue to work with Congress to find a permanent solution to the Medicare payment issue. ■

THE IMPORTANCE OF PARTICIPATION The AMCNO Relies on Our Members to Sustain Its Activities

This year, we have worked hard to retain members on the AMCNO membership roster. We are proud that our ranks have swelled to over 5,000 current members. The larger our membership number, the more clout our organization has. When we write a letter to a politician, speak to the media or testify regarding legislation, our voice is louder and receives more attention. We write those letters and make those statements on behalf of each of you, but speak with one voice.

So numbers are important. But what is more important is the individual impact each of you can have when you participate in the workings of the AMCNO. Whether you are a new or longstanding member of the AMCNO, we would like to have more from each of you than your name on our membership roster. Every one of you has skills and interests that we need in order to cultivate the needs of the medical association.

We need board members and committee members, but we also need participants in our functions. We need members like you at our educational sessions, our foundation events, our annual meeting and our social events. We welcome articles for our magazine and we welcome new participants on our award-winning Healthlines radio program. We need your letters, emails and phone calls. Your opinions are very important to us.

One of the principal indicators of success of any large organization is participation. We are here for you, and we are only here because of you. Make a commitment today to get involved with the AMCNO.

For more information contact the AMCNO offices about participating in AMCNO activities. ■

Jurisdiction 15: Announcement – Center for Medicare and Medicaid Services (CMS) J15 Award Goes to CIGNA

The Government Accounting Office (GAO) has issued its ruling on the multiple protests filed regarding the award of the Jurisdiction 15 Ohio/Kentucky MAC to CIGNA. GAO has denied each of the protests filed by various contractors.

In essence, CMS' award of J15 to CIGNA was upheld. We do not have any further information at this time, including the dates of any transitions. Palmetto GBA will continue to perform all of their services, and will notify physicians more information becomes available. CIGNA has been awarded the Medicare carrier for Part A and Part B in Ohio. This means that over the next year, the administration of Medicare payments will transition from Palmetto GBA to CIGNA. Jurisdiction 15, which includes Ohio, had been originally

awarded to Highmark, but then challenged by several other carriers. As a result of the challenge, it was then awarded to CIGNA, and challenged again by several carriers. The government has now overruled these appeals and the award went to CIGNA. We do not yet have information regarding the exact dates of the transition. As such, Palmetto GBA will continue to perform all of the current services in the interim. The AMCNO will keep you informed as we learn more about CIGNA and the transition dates. ■

MEMBERSHIP ACTIVITIES

The Business of Medicine

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) presented our annual seminar, *Preparing for the Business Aspects of Practicing Medicine* in October at the AMCNO offices.

Dr. Laura David, AMCNO President and emcee for the evening welcomed residents and spouses from several area hospitals to learn about employment contracts, liability coverage, asset management, estate planning, starting a practice, and tax concerns from a lineup of expert guest speakers. The agenda's content and speakers targeted specific issues that young physicians will face entering today's healthcare marketplace. The seminar was presented by the AMCNO and sponsored by The William E. Lower Fund and The Academy of Medicine Education Foundation (AMEF).



Several residents who participated in the "Preparing for the Business Aspect of Practicing Medicine" session strike a pose with the presenters and Dr. Laura David, AMCNO president (center).

The AMCNO and AMEF would like to thank the presenters Richard Cause and Cindy Kula from Walthall, Drake & Wallace LLP, Annette Meredith from Willis, Phil Moshier from Sagemark Consulting, James Spallino Jr., from Squire, Sanders & Dempsey and Elizabeth Sullivan from McDonald Hopkins who were on hand to share their expertise.

James Spallino introduced attendees to estate planning basics and what everyone should have on file such as a will and a general power of attorney. A young family should have a trust, a living will and a durable power of attorney for health care.

Annette Meredith stated that a physician's income-earning ability is one of their key financial assets. She explained that AMCNO resident members can apply for an association disability insurance plan at reduced rates.

Phil Moshier reminded the audience of the financial challenges medical professionals face including medical malpractice, asset preservation, liability exposure, tax brackets and estate taxation, and just why financial planning is so important.

Elizabeth Sullivan provided hot points of employment contracts, reminding the audience that before joining a practice, physicians should conduct a non-economic and economic appraisal of the prospective group to include the group's culture, nature and strength of leadership, retirement details, reputation and location. Physicians should also review the financial condition, compensation/benefits for different physician levels, retirement, practice patient population, hospital relationships, legislative/ payor initiatives or malpractice/regulatory compliance matters. She reminded everyone present that non-compete clauses are enforceable in Ohio and if a physician buys in, make certain to include buy-out options.

Richard Cause and Cindy Kula used examples to illustrate the many factors to consider when getting started in a medical practice. In structuring for success, some of the factors to consider are tax and non-tax issues of sole proprietorship or partnership (general and limited), corporation or Limited Liability Company.

The AMCNO offers this FREE seminar for residents every year. For more information please contact Linda Hale at the AMCNO offices. ■



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Health Information Technology and Enhanced Primary Care Home Workgroups Discuss Health Information Exchange

AMCNO Past President **Dr. Ronald A. Savrin** recently chaired a combined meeting of the Ohio Health Care Coverage and Quality Council's Health Information Technology (HIT) Task Force and Enhanced Primary Care Home (EPCH) Initiative workgroups. The purpose of the meeting was to ascertain how the HIT Task Force could help to eliminate HIT barriers for the EPCH projects and how to determine how the EPCH projects could most effectively integrate HIT.

It has been reported that the current data retrieval systems used in the EPCHs are difficult to use and that there are a variety of systems being used which are not always compatible. In order to enable data to be shared, there must be a common denominator or a way to generate consistent reports. Several committee members were not aware of the online resources available through the Ohio Health Information Partnership (OHIP). A representative of OHIP was on hand to provide input to both workgroups on the resources available through OHIP. The representative indicated that OHIP has the funding to create, and is in the process of creating, a Health Information Exchange (HIE). The HIE will connect labs, hospitals, and physicians across the state. The components needed for the HIE are: a master patient index, a master entity

index, health records, and a privacy/security system. A contract will be finalized at the end of the year, and OHIP hopes to have the HIE available by June/July 2011. There will be an administrative fee for the exchange.

The HIT task force and the EPCH steering committee identified and prioritized several needs and priorities:

Priority One: EHR Education

- *Intelligent selection of EHR:* Practices need access to information about different systems and upgrades in order to make informed selections.
- *Physician Education and Communication:* Physicians are not always making the most efficient and effective use of EHRs.

Priority Two: Data Management

- *Management of Incoming Data:* Practitioners have difficulty prioritizing incoming data and desire an automated way of prioritization.
- *EHR Reports:* Practitioners using EHRs in the medical home setting are having challenges getting information back out of the systems they are using to do reporting and analysis.
- *Referral Tracking:* Practitioners can't always track referrals in their EHR systems and need ways to get structured data and not just images.

Priority Three: Quality Reporting

- *Practitioners in the medical home would like to have the ability to use their EHR systems to do some quality reporting, such as on PQRI measures.*

Moving forward the group plans a collaborative effort between OHIP, the HIT task force and the EPCH steering committee to address the identified needs. ■

The Office of the National Coordinator Provides Insight On Health Information Technology Priorities

More than 230 physicians and health care professionals including representatives from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) learned about the innovative use of electronic health records (known as EHRs) at an all-day conference at The Ohio State University sponsored by the Ohio Health Information Partnership (OHIP). The progressive push is on to improve Ohio's health care system so doctors, hospitals, health care facilities and pharmacies can electronically and securely share patient information, which should improve both the quality and the continuity of health care for Ohioans.

"This is the wave of the future — it is here," said Thomas Tsang, M.D., M.P.H., a public health expert from the Office of the National Coordinator for Health Information Technology in the Department of Health & Human Services in Washington, D.C. "This is our chance to think about what we're doing for the health of our nation. It's also allowing and empowering you to take control of community care. What's the best system Ohio can create?" he asked the crowd during his keynote address.

Dr. Tsang said the federal Health Information Technology Committee's priorities are to:

- Improve quality, safety, efficiency and reduce health disparities
- Engage patients and families in their health care

- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

While some doctors and hospitals already have their own electronic health records, they don't "talk to one another," Dr. Tsang explained. Nationally, standards and certification rules now developed could potentially allow an emergency room physician in California to share records with a doctor in Ohio, he said.

Recent findings from the 2009 National Healthcare Quality Report show that internationally, the U.S. is rated 26th in infant mortality and 37th in overall health care, yet the nation is No. 1 in total expenditures. "We need to reduce inefficiencies while improving



Thomas Tsang, M.D., M.P.H., a public health expert from the Office of the National Coordinator for Health Information Technology provides his comments at the OHIP event.

quality, and HIT can help facilitate that," Tsang said.

The AMCNO has physician and staff representation on OHIP committees and we are integrally involved at both the state and regional level with OHIP and the regional extension center activities. To find out more about OHIP and regional extension centers, go to: www.ohiponline.org. To directly view workshop presentations, go to: <http://ohiponline.org/Pages/EducationalEventHandouts.aspx> ■

AMCNO Hosts 26th Annual Mini-Internship Program

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) was pleased to host the 26th Annual Mini-Internship Program October 11 through 13 with member physicians and interns. Community leaders volunteered as interns and paired up with physicians to participate in a two-day program to view first hand “through the eyes of a physician” the demands of practicing medicine.

The program opened with an orientation dinner providing an opportunity for physicians and interns to meet, get acquainted and learn more about their new roles. Chairman, **William Seitz, Jr., M.D.**, shared program initiatives and outlined what the interns may experience. Greg Viviani, Squire Sanders, provided HIPAA training for interns.

After two days of a continuous schedule of heart surgery, hysterectomy surgery, shoulder surgery, gall bladder surgery, total knee replacement, well child office visits and hospital rounds a debriefing dinner was held at the end of the event. Interns were eager to share their poignant experiences that they will take with them providing a new perspective on what a physician really does on a daily basis.

The AMCNO expresses its sincerest appreciation to participating physicians and interns for committing their time and effort to make this a unique program and continue the tradition of excellence year after year. For more information on Mini-Internship opportunity, contact the AMCNO Communications Department at (216) 520-1000 extension 102.

“It was a pleasure to host the interns.”

Dr. Christopher McHenry



Several participants in the mini-internship program spend a moment during the orientation event – left to right – **Dr. William Seitz, Dr. Shyam Bhakta, Robin Cottingham, Amanda Whitener, Brie Zeltner, Dr. Matthew Levy, Dr. Diane Butler, and Dr. Christopher McHenry.**

“The community will benefit from the experience of the interns.”

Dr. William Seitz, Jr.

“It was amazing to witness a total knee replacement and it was exhausting how Dr. Keppler went from room to room nonstop.”

Brie Zeltner



Dr. William Seitz, Dr. Shyam Bhakta, Robin Cottingham, and Dr. Christopher McHenry.

“It was a cool experience to witness a complete surgery. It was an amazing experience.”

“It was a fantastic experience being on board and close up.”

Robin Cottingham

“This experience has been awesome! This was a relevant experience to take back to my team at the Great Lakes Science Center.”

Amanda Whitener



The interns pose with some of the physicians participating in the mini-internship event – left to right - **Dr. Diane Butler, Dr. Tom Abelson, Dr. Matthew Levy, Dr. William Seitz.** Front row: **Dr. Laura David, Amanda Whitener, Brie Zeltner, Robin Cottingham, and Dr. Shyam Bhakta.**



Dr. William Seitz, Amanda Whitener, Dr. Christopher McHenry, and Dr. Tom Abelson.

“We enjoy teaching an art.”

Dr. Matthew Levy



Dr. Matthew Levy, Brie Zeltner, Dr. Diane Butler, and Dr. Tom Abelson.

“Doctors are real people. This program portrays that it is a lot of fun to show interns what we do. We get satisfaction doing the best we can.”

Dr. Tom Abelson

2010 Physician Participants

William H. Seitz, Jr., M.D., Chairman
Tom I. Abelson, M.D.
Shyam Bhakta, M.D.
Diane A. Butler, M.D.
Robert L. Debernardo, M.D.
Louis Keppler, M.D.
Matthew E. Levy, M.D.
Christopher R. McHenry, M.D.

2010 Program Interns

Robin Cottingham, Chair
Center for Community Solutions
Senior Vice President, KeyBank N.A.

Amanda Whitener
Manager, Visitor Experience
Great Lakes Science Center

Brie Zeltner
Medical Reporter
The Plain Dealer

AMCNO ACTIVITIES

2011 Cuyahoga Community College Center for Health Industry Solutions



Take advantage of discounted classes for AMCNO Members and their staff. Contact Linda Hale at 216-520-1000 for exclusive AMCNO member course numbers to register and take advantage of the discounted price.

Date/Time	Title	Fee		Location
Jan 10-Feb 23 6:00-9:00 pm (M & W)	Medical Terminology	\$253 call AMCNO for discount price	39 hrs.	CCW
Jan 11-Feb 22 9:00 am-12 noon (T & Th)	Medical Terminology	\$253 call AMCNO for discount price	39 hrs.	UTC
Jan 18-Apr 19 T & Th Evenings 6-9 pm	AAPC Professional Medical Coding Curriculum	\$1651 call AMCNO for discount price	81 hrs	CCW
Feb 7-Mar 23 6:00-9:00 pm (M & W)	Medical Terminology	\$253 call AMCNO for discount price	39 hrs	CCE
Feb 9 9:00 am-12 noon	Denials & Appeals: common mistakes & tips for getting that denial reversed	\$159 (\$139 AMCNO)	CEUs: 3	CCE
Feb 14-Mar 9 6:00-9:00 pm (M & W)	Fundamentals of Billing Reimbursement	\$283 call AMCNO for discount price	24 hrs	CCE
Feb 26-April 23 Saturday mornings 9 am-1pm	Accelerated AAPC Professional Medical Coding Curriculum	\$850 call AMCNO for discount price	36 hrs	CCE
Mar 1 – Mar 24 9:00 am-12 noon (T & Th)	Fundamentals of Billing Reimbursement	\$283 call AMCNO for discount price	24 hrs	UTC
March 9 8:30 am-12 noon	Confident Communication with Providers about Coding Issues	\$159 (\$139 AMCNO)	CEUs: 3.5	CCE
March 23 9:00 am-3:30 pm	ICD 9-CM Fundamentals and More	\$199 (\$179 AMCNO)	CEUs: 6	CCE
April 6 8:00 am-12:30 pm	ICD-10 Preparation: Review of ICD-10 Structure + Anatomy, Physiology & Medical Terminology	\$135 (\$120 AMCNO)	CEUs: 4.5	CCE
April 13 9:00 am-3:30 pm	CPT Coding Fundamentals and More	\$199 (\$179 AMCNO)	CEUs: 6	CCE

Course Locations: **Corporate College East** 4400 Richmond Rd, Warrensville Hts, OH 44128 • **Corporate College West** 25425 Center Ridge, Westlake, OH 44145 • **Unified Technologies Center**, 2415 Woodland Ave, Cleveland, OH 44115

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