

AMCNO Spearheads Medical Legal Partnership Initiative

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to host a Medical Legal Partnership stakeholder meeting at our facility. The purpose of the meeting was to bring together representatives from the Northern Ohio community to learn about the medical legal partnership (MLP) concept.

In 2002, The Legal Aid Society of Cleveland — the law firm for low-income individuals in Northeast Ohio — began a partnership with MetroHealth to help patients resolve some of the social issues that were exacerbating their health problems. The collaboration is known as the “Community Advocacy Program” (CAP). CAP is able to find

solutions to help patients get and stay healthy, including income support for food insecure families, utility shut-off protections during cold winter months, and mold removal in the home of asthmatic children.

Cleveland’s Community Advocacy Program is the first of its kind in Ohio and the fifth of its



Dr. Laura David, AMCNO President, provides the opening comments at the Medical Legal Partnership meeting convened at the AMCNO offices.

kind in the nation. The integration of legal services into health settings has been embraced and replicated by hospitals and health centers across the country. Collectively known as the “Medical-Legal Partnership Network,” medical-legal partnership (MLP)

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Ohio Supreme Court to Consider Whether a Claim for Lack of Informed Consent Constitutes a “Medical Claim” for Which a Plaintiff is Required to Present Competent Expert Testimony to Establish a *Prima Facie* Claim

By Bret Perry, Esq. and Jennifer Becker, Esq., Attorneys With Bonezzi Switzer Murphy Polito & Hupp Co. L.P.A.

AMCNO Files Amicus Brief On Behalf of Our Members

The AMCNO Medical Legal Liaison Committee tracks cases for the AMCNO Board of Directors that come before the Ohio Supreme Court and could impact or change the law in Ohio concerning our physician members. As a result, the AMCNO became aware of such a case and we have filed an Amicus Brief on behalf of our members in the case described below.

The Ohio Supreme Court will soon consider whether a claim for lack of informed consent constitutes a “medical claim” which would require a Plaintiff to offer competent medical expert testimony to

establish a *prima facie* claim or whether this type of allegation constitutes a common-law claim for battery. More importantly, in considering this proposition, the Ohio

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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.

Ohio Supreme Court to Consider Whether a Claim for Lack of Informed Consent Constitutes a “Medical Claim” for Which a Plaintiff is Required to Present Competent Expert Testimony to Establish a *Prima Facie* Claim

(Continued from page 1)

Supreme Court will indirectly determine whether a claim for lack of informed consent is subject to Ohio’s medical malpractice tort-reform monetary damage caps.

This matter stems from the Tenth District Court of Appeals decision in *White v. Leimbach*, 10th Dist. No. 09AP-674, 2010-Ohio-1726 wherein the Court held that a claim for lack of informed consent is not a “medical claim,” but rather a common-law claim for battery. The Tenth District determined that expert testimony was not necessary to establish a claim for lack of informed consent and went as far as denying that any such requirement previously existed under Ohio law. This decision, if left undisturbed, could have a negative impact on physicians throughout Ohio resulting in an overwhelming increase in the number of lawsuits claiming lack of informed consent by virtue of the “loophole” created by the Tenth District which now permits these types of claims to proceed to trial without the otherwise absolutely necessary expert medical testimony. More concerning, the Tenth District’s decision could be interpreted to find that a claims for lack of informed consent do not fall under the purview of Ohio medical malpractice tort-reform monetary damage caps in that these claims are no longer “medical claims” but instead common-law battery claims.

On behalf of AMCNO, Bret C. Perry, Esq. and Jennifer R. Becker, Esq., filed an *Amicus* brief (literally “Friend of the Court”), with the Ohio Supreme Court urging reversal of the Tenth District Court of Appeals decision. An *Amicus* filing generally allows individuals and entities who are not parties to a case, but who have an interest in the outcome, to have an opportunity to be heard.

The *Amicus* brief on behalf of the AMCNO encourages the Ohio Supreme Court to find that a claim for lack of informed consent constitutes a “medical claim” that is only established when: 1) the physician fails to disclose to the patient and discuss the material risks and dangers inherently and potentially involved with respect to the procedure, if any; 2) the unrevealed risks and dangers which should have been disclosed by the physician actually materialize and are the proximate cause of the injury to the patient; and 3) a reasonable person in the position of the patient would have decided against the procedure had the material risks and dangers inherent and incidental to treatment been disclosed to him or her prior to the procedure. *Nickell v. Gonzalez* (1985), 17 Ohio St. 3d 136, at syllabus.

As a fundamental rule of law regarding medical claims, expert testimony is necessary to establish: 1) the standard of care recognized by the medical community; 2) failure on the part of the defendant-physician to meet the standard of care; and 3) direct causal connection between the negligent act and the injury sustained. *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127.

The *Amicus* brief cited prior Ohio case law that held that a claim for lack of informed consent constitutes a “medical claim” and that expert testimony is always required to establish the essential elements of this claim. For example, the First District Court of Appeals has held that “[g]enerally, the plaintiff has the burden of proving by expert medical evidence what a reasonable medical practitioner of the same discipline, practicing in the same or similar communities under the same or similar circumstances, would have disclosed to his patient about the risks incident to a proposed treatment, and of proving that the physician departed from that standard.” *Bedel v. University OB/GYN Assocs.* (1991), 76 Ohio App. 3d 742, at 744. The Third District Court of Appeals specifically held that an informed consent claim arises out of the medical care, diagnosis or treatment of a patient and must be classified as a “medical claim”. *Grandillo v. Montesclaros* (2000), 137 Ohio App.3d 691, at 700.

Similarly, the Eighth District Court of Appeals held that “a claim for lack of informed consent is indeed a medical claim” because it “arises out of the medical diagnosis, care, or treatment of any person.” *Turner v. Cleveland Clinic Found.*, 8th Dist. No. 80949, 2002-Ohio-4790, at ¶134. The Court explained that, “because a claim for lack of informed consent is a medical claim, ‘the plaintiff has the burden of proving by expert medical evidence what a reasonable medical practitioner *** would have disclosed to his patient about the risks incident to a proposed treatment ***.’ In short, the plaintiff has the burden of proving — through expert testimony — the standard of care.” [citations omitted]. *Turner*, at ¶135.

The *Amicus* brief on behalf of AMCNO contends that the Tenth District’s decision has caused ambiguity and uncertainty that will undoubtedly result in disparate treatment of physicians if left undisturbed. As a result of this decision, the Tenth District Court of Appeals essentially created a new evidentiary standard finding that expert

testimony is not required to establish a *prima facie* claim for lack of informed consent. Consequently, there is a likelihood of increased litigation and the number of lack of informed consent claims being filed by litigants exploiting this judicially created “loophole” when unable to meet the burden of producing expert testimony for “medical claims” alleging lack of informed consent.

Just as concerning, the decision of the Tenth District Court of Appeals held that a claim for lack of informed consent was merely a common-law claim for battery and not a “medical claim.” O.R.C. 2323.43, effective April 11, 2003, limits the amount of noneconomic damages (pain and suffering) that may be awarded in medical malpractice claims. The amount of the damage cap is dependent upon whether the injury is a catastrophic or non-catastrophic injury. When a catastrophic injury has occurred, such as permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, damages are limited to the greater of three times economic damages or \$500,000 per plaintiff. The maximum recoverable per occurrence is \$1,000,000. When a non-catastrophic injury has occurred, damages are limited to the greater of three times economic damages to a maximum of \$350,000 per plaintiff, or \$250,000 per plaintiff. The maximum amount recoverable is \$500,000 for each occurrence. As currently situated, the Tenth District Court of Appeals determination that claims for lack of informed consent are not “medical claims,” and are merely common-law claims for battery, potentially exposes physicians to increased liability in that the noneconomic damage caps set forth in O.R.C. 2323.43 would arguably not apply.

The AMCNO is the only organization to file an *Amicus* brief in this case noting the potential negative impact on its members if left undisturbed. The decision of the Tenth District, if not reversed, will permit otherwise meritless claims to proceed to trial without the necessary expert medical testimony. More importantly, this decision could potentially subject physicians to increased liability should this holding be construed in a manner to exclude claims for lack of informed consent from Ohio’s medical malpractice tort reform protections. This is not the law of Ohio and AMCNO seeks to close this dangerous and judicially created “loophole” by requesting that the Supreme Court reverse the Tenth District’s decision. ■

New Ohio Supreme Court Chief Justice Takes Oath of Office — AMCNO Leadership Attends Ceremony

Justice Maureen O'Connor was ceremoniously administered the oath of office in January before a capacity crowd (which included representatives from the Academy of Medicine of Cleveland & Northern Ohio) in the Ohio Supreme Court, becoming the first woman to hold the post of Chief Justice since the court's creation in 1803.

Justice O'Connor said she hoped, in partnership with her colleagues on the court, to articulate a vision for the judicial branch of state government. She outlined four areas of challenge: budget, diversity, impartiality, and collaboration.

With regard to the budget she proposed a 10% cut in the court's discretionary biennial budget and indicated that she will establish a bipartisan Task Force on the Judicial Budget to examine the current structure and funding of the judicial branch.

On the topic of diversity, Justice O'Connor said that less than one in four judges in Ohio are women, although Ohio's population is 50% women. She also noted that there are other

populations that could be better represented stating that until we have a bench and a bar in Ohio that is truly representative of our diverse population, there is still much work to be done in this area.

To increase impartiality in the election process the chief justice proposed holding non-partisan primaries that remove party affiliations from the names of judicial candidates on the ballot. In addition, she endorsed making gubernatorial appointments to fill Supreme Court vacancies subject to Senate confirmation.

She noted that there are different challenges and concerns of local courts and judges across the state. So in order to increase collaboration



The new Chief Justice spends a moment with Dr. Anthony Bacevice, AMCNO Immediate Past President (l) and Mr. David Watson, Executive Director of the Cleveland Metropolitan Bar Association. (The AMCNO has begun to work with the CMBA on joint projects – see page 6 of this issue for information on our upcoming joint seminar).

she plans to take trips across the state to meet with and listen to courts and bar associations on a regular basis.

She closed with the words of her friend and colleague, the late Chief Justice Moyer: "Let us leave here with a renewed spirit and hope for the American ideal of justice for all. Let us recommit, let us rededicate ourselves to the expectations that justice is achieved through the virtuous acts of judges bound by the principles of impartiality and fairness," she said. ■

AMCNO Spearheads Medical Legal Partnership Initiative

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programs now operate in more than 225 health institutions in 38 states, serving children, the elderly, disabled adults, cancer patients and other vulnerable populations.



Participants in the Medical Legal Partnership stakeholder meeting pose questions to the staff from the Legal Aid Society of Cleveland

In July 2010, the bi-partisan MLP for Health Act calling for a major federal demonstration project for MLP was introduced in the U.S. House of Representatives and the U.S. Senate. The bills authorized funds through the Department of Health and Human Services to evaluate the effectiveness of medical-legal partnerships and to provide recommendations for improving the model to better serve vulnerable populations across the country. The AMCNO is working with the MLP to assure that these bills are re-introduced in order to have this issue come before the new Congress.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has begun working with the Legal Aid Society and many other stakeholders in the community including hospitals, health care-related organizations, and local law firms to garner additional support for the medical-legal partnership concept and the legislation. This is an important issue for the AMCNO and for our community and we plan to continue the stakeholder discussions and the push for passage of legislation in Congress that would provide additional support to medical legal partnerships in our community. For more information on this initiative contact the AMCNO at 216-520-1000. ■

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.

Sagemark Consulting also offers comprehensive financial planning to help you with your goals in:

- Retirement Planning
- Investment Planning
- Education Analysis
- Insurance Review
- Employee Benefits
- Estate Planning

Please contact us for your consultation today at:

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30700 Bainbridge Road, Suite B
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Issues Involving the Ownership, Retention and Storage of Patient Records and the Notification of Patients When a Physician Leaves a Group Practice

By John Mulligan, Esq., McDonald, Hopkins LLP

Among the questions that a practice group faces when a physician leaves the group are those involving who owns the medical records of patients served by the physicians, what rights the terminating physician has to access those records or make copies of them, what sort of patient notification is required and what ongoing record maintenance/storage requirements the group has. To a large extent the answer to these questions depends on whether the physician intends to remain in the area and continue to practice medicine serving the same patients, or whether the physician is terminating medical practice or relocating to another area.

Generally, the medical practice entity, such as a corporation or limited liability company, which employs the physician will be the owner of the patient records. This would mean that the physician would have no right to unilaterally take the records, or even to make copies of them, unless that was agreed to by the group or requested by the patient. However, there are situations where that may not be the case, as, for example, where the physician had an established practice prior to joining the group and brought those patient records with him or her without transferring ownership of the records. The written agreements by which an established practitioner joins a group (or, for that matter, any physician employment contract) should specifically cover the ownership of the physician's records and spell out the rights of the physician if he or she left the group.

The ethical opinions published by the American Medical Association (AMA) address the issue of the notification of patients when a physician leaves a group practice. Issues involving the AMA's ethical rules are significant in that they have the force of law in Ohio and violations can result in disciplinary action by the State Medical Board. The AMA ethical opinions provide that if a physician leaves a group practice the patients of the physician should be notified. In correspondence to this writer several years ago, an AMA representative stated that this did not obligate the group to initiate correspondence to patients, but simply required the group to provide information to inquiring patients.

In any situation in which the physician who is terminating association with the group will also be terminating physician patient relationships, there are patient notification requirements under Ohio law. The Ohio State Medical Board has adopted regulations with respect to the termination of the physician patient

relationship. Where the physician is terminating his or her association with the group and will not be continuing to provide, or be available to provide, services to his or her patients, the regulation mandates certain patient notice. These notice requirements do not apply in a situation which the physician has only rendered service to a patient on an episodic or emergency basis and where the physician could not reasonably expect that related medical services will be rendered to this patient in the future. The requirements also do not apply if the physician has formally transferred the patient's care to another physician who is not in the same group practice.

Otherwise, a physician who is leaving a practice, selling a practice, or retiring from medical practice must do the following to formally terminate physician patient relationships:

- Mail a notice by regular mail addressed to the last known address to all patients seen by the physician within the immediately preceding three years;
- Publish a notice in the newspaper of greatest circulation in each county in which the physician practiced and in a local newspaper that serves the immediate practice area; and
- Post a sign in a conspicuous location in or on the façade of the physician's office.

The required notices and sign must advise patients of their opportunity to transfer or receive their records. For patient records remaining in the physician's possession once the physician is no longer seeing patients, the notices and sign must provide contact information for obtaining the records.

Physician groups typically have an interest in controlling the manner in which patient

notices are given to the patients of physicians who are leaving the group. Because of this, it is advisable to include a provision in the employment contract between the group and the physician which spells out the fact that the group will determine the manner of and will discharge, all responsibilities with respect to patient notification. However, ultimately the responsibility for notifying the patients rests with the physician, and the physician could (and, indeed, should) force the group to make the notification if it failed to do so.

Some physicians ask whether, even if the group provides the required notice, they have the right to notify patients of their departure. Generally, the physician does not have this right unless it is specifically provided for in a contract between the physician and the group. If the physician wishes to be able to notify patients upon leaving the group, then this is something that should be included in the physician's employment contract.

Another medical records issue involves the obligation to maintain or store medical records. The agreements between a group and its physicians should specify what obligation the group has to maintain or store the records after the physician has separated from the group. This can become a significant issue with regard to "old" records for patients who may no longer be receiving services from either the terminating physician or from any other physician in the group. The legal aspects of retaining patient records are beyond the intended scope of this article. However, it is recommended that the responsibility of the group to maintain the records be dealt with in its agreements with its physicians.

Dealing with the "old" records of physicians who have terminated from the group can create a number of practical issues. For example, if the group subsequently, breaks up, what happens to the "old" records of physicians who had left previously? Who will pay the costs of off site storage, a cost which can be significant each year for many years? Who will be responsible for providing copies of requested records? When and at whose direction can those records be destroyed?

Groups should consider requiring any physician who terminates from the group to be responsible for the storage of any record which the group will not need for ongoing medical care for the patient. This is another issue which should be dealt with in any physician employment contract.

For more information about patients and their medical records see the AMCNO Medical Record Fact sheet insert included in this issue. ■

Medical Malpractice Issues for Attorneys & Physicians

Wednesday, April 6, 2011
 5 PM Cocktails/Dinner, 6 – 8 PM Program
 Cleveland Metropolitan Bar Association
 1301 E. Ninth St., 2nd level, Cleveland 44114

Jointly Sponsored By:



Program Format:

Welcome: **Laura J. David, M.D.**, AMCNO President
Michael N. Ungar Esq., CMBA President

Moderator: **George M. Moscarino, Esq.**, Moscarino & Treu, LLP

5:00 p.m. – 6:00 pm — Dinner

6:00 p.m. – 6:30 p.m.
James J. McMonagle, Esq.
Vorys, Sater, Seymour & Pease, L.L.P.

- **Reflections on Medical Malpractice Cases: Judge, General Counsel and Mediator.** Commentary on the common themes in medical malpractice cases from filing to conclusion by trial or settlement, including the impact of litigation on both the physicians and litigants.

7:00 p.m. – 7:30 p.m.
Kim F. Bixenstine, Esq.
V.P. & Deputy General Counsel/ University Hospitals of Cleveland

Matthew J. Donnelly, Esq.
Director of Litigation/The Cleveland Clinic Foundation

6:30 p.m. – 7:00 p.m.
John A. Lancione, Esq.
Lancione & Lancione, P.L.L.

- **Medical Malpractice in Ohio: Observations from the Plaintiffs' Bar.** Learn about case selection and the decision-making process on suits against doctors / hospitals, as well as insight into the prosecution of malpractice suits in the post-Tort Reform era. Topics include the impact of the Affidavit of Merit and recent Supreme Court decisions.

- **Current Trends in Medical Malpractice Litigation: the Hospital In-House Counsel Perspective.** Recent trends and emerging litigation risks including the impact of the internet. Practical tips for dealing with malpractice cases for physicians and counsel on both sides of these lawsuits.

7:30 p.m. – 8:00 p.m.
 • **Panel Discussion/Q & A**

Meet the Presenters

KIM F. BIXENSTINE, Esq., Vice President and Deputy General Counsel of University Hospitals, Kim is the current chair of the system-wide Risk Management Council and is responsible for training and legal counseling for the system including the parent company (University Hospitals), University Hospitals Case Medical Center, seven community medical centers, University Hospitals Home Care Services, Inc., and two physician groups University Hospitals Medical Group and University Hospitals Medical Practices

MATTHEW J. DONNELLY, Esq., Director of Litigation in the Cleveland Clinic Foundation Law Department. His responsibilities include: directing and managing claims and litigation involving professional, commercial and general liability at Cleveland Clinic's main campus, nine regional hospitals, fifteen family health centers and Cleveland Clinic Florida as well as legal counseling to Cleveland Clinic's physicians, nurses and business units.

JOHN A. LANCIONE, Esq., An Ohio medical malpractice attorney at Lancione & Lancione, P.L.L. has over nineteen years of legal experience and is admitted to practice law in Ohio. Mr. Lancione received his undergraduate degree in Political Science from Denison University and his law degree from the Case Western Reserve University School of Law in 1988. He is invited frequently to lecture on topics of medical malpractice nationally and throughout Ohio, and he has testified before the Ohio Senate and House Committees on medical malpractice.

JAMES J. McMONAGLE, Esq., is of counsel in the Vorys Cleveland office and a member of the corporate and finance and litigation practice groups. He has been involved with the mediation and arbitration of complex cases throughout the United States, including tort business, securities and employment litigation as well as unwinding and restructuring businesses as a result of unexpected market changes. Prior to joining Vorys, Sater, Jim served as General Counsel for University Hospitals of Cleveland and as a Judge on the Cuyahoga County Court of Common Pleas for 13 years.

REGISTRATION FORM

Proudly co-sponsored by:

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 The Cleveland Metropolitan Bar Association (CMBA)
 The Academy of Medicine Education

FEES:
 \$15.00 - LAW STUDENTS/ MEDICAL STUDENTS
 \$35.00 - AMCNO OR CMBA MEMBERS
 \$50.00 - NON-MEMBER

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Physician registration

By phone/fax or mail to: **AMCNO**
 6100 Oak Tree Blvd., #440, Cleveland 44131
 Phone 216-520-1000; FAX 216-520-0999
www.amcno.org to download this form

The AMCNO has obtained approval from University Hospitals (UH) for two hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program.

Attorney registration

By phone/fax/mail or online to **CMBA**
 1301 E. Ninth St., Cleveland 44114
 Phone 216-696-3525; FAX 216-696-2129
www.clemetrobar.org

The CMBA has requested 2.0 hours of CLE credit from the Supreme Court of Ohio Commission on CLE.

Cancellations must be received in writing three business days prior to the program. Refunds are charged a \$15 administrative fee. Transfers or substitutions to other programs are permitted with 24 hours written notice. (Transfer is to a single program and funds may be transferred only once!) Persons with disabilities needing special arrangements to attend this program, please contact the CMBA at (216) 696-2404 one week prior to the program.

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AMCNO Legislative Update

By Connor Patton, AMCNO Lobbyist

Governor Kasich Takes Office

In January, John Kasich took office as the new Governor of Ohio and so far, he is staying true to his campaign pledge to eliminate state government red tape, explore new ways to create revenue for the state, incentivize job creation, and make government more efficient. Governor Kasich began these tasks by announcing a new public private partnership to replace the Ohio Department of Development called JobsOhio. He also devised a Common Sense Initiative to aid small business and mandate state agencies to review rules and regulations that impede Ohio businesses and prevent job growth. In order to streamline state health and human service delivery he capped off his first week by creating a new Ohio Office of Health Transformation (OHT).

Changes Underway in the Legislature and State Agencies

Under the leadership of new Republican Speaker of the House Bill Batchelder (R-Medina), the Ohio House of Representatives underwent changes to encourage public participation and availability and make the committee process more efficient. The total number of full standing committees in the House dropped from 27 to 17. The House also added evening committee hearings in order to make it easier for Ohioans to attend the committees without having to miss school or work.

The Ohio General Assembly will be tackling some colossal issues in this session that will cover areas such as: healthcare and Medicaid reform, oil and gas development, public employee collective bargaining, privatization of state services, school funding, workers compensation reform, criminal sentencing reform, redistricting, and a possible \$8-\$10 billion budget deficit. The state operating budget will contain most of these issues and is to be introduced by March 15th with final passage due by July 1st.

As noted above, Governor Kasich has created the Governor's Office of Health Transformation (OHT), and appointed veteran public and private health system consultant Greg Moody as its director. The order states, "All cabinet agencies, boards and commissions shall comply with any requests or directives issued by the OHT

executive director or the OHT executive director's designee, subject to the supervision of their respective agency directors."

Kasich also named new directors for the Department of Aging, Department of Health, and Office of Ohio Health Plans (Medicaid). Together with the state health and human services agencies (Aging, Health, ODADAS, Mental Health, Developmental Disabilities, ODJFS), as well as the Office of Budget and Management and the Department of Administrative Services, OHT will lead the effort to modernize the state's fragmented Medicaid program and implement cost-containment strategies. OHT will also draw upon public and private sector best practices to improve Medicaid's overall performance.

OHT has been charged with four tasks to be accomplished within its first six months, the biggest of which is to eventually devise a permanent health and human services organizational structure and oversee transition to that structure. Additional tasks are advocating the administration's "modernization and cost-containment priorities" for Medicaid in the forthcoming biennial budget; initiating and guiding planning for an insurance market exchange; and engaging the private sector "to set clear expectations for overall health system performance."

OHT also will use news media, social media, and other forms of communication to keep the public apprised on the development of these changes. OHT has already launched a new website www.healthtransformation.ohio.gov. The site will be utilized to provide a platform for stakeholders to become engaged and share their ideas on issues related to Medicaid and other health transformation issues. OHT is encouraging public stakeholders to get involved with the Ohio's Health Transformation efforts by signing up for email updates and following their activities on Twitter.

MEET THE NEW HEALTH AND HUMAN SERVICES AGENCY DIRECTORS

Dr. Theodore (Ted) Wymyslo, Director of the Ohio Department of Health

Dr. Wymyslo has 30 years of experience in primary care as a practicing family physician, educator and administrator. Most recently,

he has been a strong advocate for implementing the patient-centered medical home model of care in Ohio. Wymyslo previously served as the Program Director of the Family Practice Residency Program at the Miami Valley Hospital for 18 years. He received his M.D. from The Ohio State University College of Medicine.

Dr. Bonnie Kantor-Burman, Director of the Ohio Department of Aging

Dr. Kantor-Burman is a national leader in aging policy. Since 2007, she has served as the Executive Director of Pioneer Network, a national center dedicated to the development of consumer-directed, long-term care delivery systems that are high quality and cost-effective. Before taking this national position, she was the Director of the Office of Geriatrics and Gerontology at the Ohio State University Health Sciences Center for more than 15 years. She has a Doctor of Science (Sc.D.) from Johns Hopkins Bloomberg School of Public Health.

John McCarthy, Director of the Office of Ohio Health Plans (Medicaid)

Mr. McCarthy is currently the Medicaid director in the District of Columbia. His Medicaid management experience gained in D.C. puts him in a strong position to accomplish much of what needs to be done in Ohio, such as building a stronger working relationship among all the state agencies that provide Medicaid services and improving quality and value. McCarthy has previously worked with ODJFS and the Ohio Department of Developmental Disabilities on a number of Medicaid redesign projects and is familiar with Ohio and its structure. McCarthy earned his master's of public affairs from Indiana University School of Public Affairs.

Greg Moody, Director of the Governor's Office of Health Transformation

Mr. Moody's expertise includes work with both private and public sector health systems and he has 20 years of experience working with Medicaid program design and cost containment. Since 2004, Moody has been a senior consultant at Health Management Associates, Inc. where he has provided health research and consulting services to health care providers and advocacy organizations nationwide. He formerly served as Executive Assistant for Health and Human Services under Governor Bob Taft, and began his public service career in 1991 as a budget associate on then-U.S. Rep. John Kasich's House Budget Committee. Moody has a master's degree in philosophy and health policy from George Washington University.

HB 93 Introduced to Address Prescription Drug Issues in Ohio

Legislators are reviewing legislation that would penalize "rogue prescribers" that contribute to the rising addiction of prescription medications in Ohio. Rep. David Burke, a pharmacist from Marysville, and Rep. Terry Johnson, a former Scioto County Coroner, introduced HB 93 to expand prescription drug regulations and address prescription drug abuse that has risen to epidemic proportions in rural southern Ohio and Ohio's inner city neighborhoods. In various parts of the state prescription drug abuse has become a major source of criminal activity which adds additional costs to state and local governments. According to the Ohio Department of Alcohol and Drug Addiction Services, a strong example of this abuse is in Scioto County, where providers prescribed 9.8 million doses of prescription opiates in 2010, enough for 123 doses for every county resident.

These providers operate what are referred to as "pill mills" where it is very easy to obtain an illegal drug prescription. The legislation contains a number of provisions aimed at improving enforcement of prescription drug regulations, such as requiring that prescribers report dispensing to Ohio Automated Rx Review System (OARRS). Currently OARRS can't tell pharmacists if an individual had just filled the same prescription 20 minutes earlier. Speaker of the Ohio House of Representatives Bill Batchelder has signed on as a co-sponsor, which indicates the legislation will probably pass out of the chamber. Other provisions will:

- Create a \$150 Terminal Distributor License with a Pain Management Clinic classification.
- Establish a penalty of up to \$20,000 for physicians who fail to obtain a license.
- Define "pain management clinics" with an exemption for hospitals, medical and dental schools, and hospice.
- Authorize the State Board of Pharmacy to suspend a terminal distributor license if there is clear and convincing evidence that the provider presents a danger of immediate and serious harm to others.
- Prohibit providers from dispensing controlled substances that exceed a 24-hour dosage.

- Restrict prescribers' ability to dispense controlled substances that exceed 2,500 dosage units in any 30-day period.
- Require Medicaid recipients who are found to have obtained drugs that are not medically necessary to fill prescriptions at a single pharmacy.
- Authorize the Board of Pharmacy, ODADAS, and the Attorney General's Office to create a statewide Drug Take Back Program.
- Require the Board of Pharmacy to recommend improvements to General Assembly within six months of passage.

Just before press time a substitute bill was agreed to that expands the definition of a pain management clinic and provides that the State Medical Board may establish other criteria to define such a clinic in the future. A new provision requires owners of pain management clinics to supervise, control and direct the activities of employees, volunteers or persons under contract providing services to the clinic. The substitute also includes ambulatory surgical facilities, along with hospitals, medical or dental schools and hospice programs, within pain management clinic licensure.

Under the substitute, the office of the Attorney General would be solely responsible for the costs incurred in the establishment and administration of the drug take-back program and changes the date of the first collection to not later than one year after the bill's effective date. The original bill divided the cost of the administering the program among the attorney general, Department of Alcohol and Drug Addiction Services and the State Board of Pharmacy and established the first take-back collection date of Dec. 31, 2011.

The physician reporting requirement of drugs that are controlled substances and other drugs included in the Ohio Automated Rx Reporting System (OARRS) was expanded to all prescribers who personally furnish the drugs and includes dentists and podiatrists within the groups subject to disciplinary action for failing to report the information.

The substitute also permits a coroner to notify and provide information to the Medical Board when the coroner determines

that a drug overdose caused a death.

Attorney General Mike DeWine has also announced that he plans to devote more funding and staff to combat prescription drug abuse in the state. Mr. DeWine appointed Adams County Prosecutor Aaron Haslam to serve as his "point man" on prescription drug abuse to coordinate efforts with local law enforcement officials.

He also hired two additional attorneys to help prepare cases and assist local prosecutors. The attorney general also said he would dedicate funds for the Ohio Peace Officer Training Academy to train law enforcement agents and for the Bureau of Criminal Investigation to assist local authorities fight prescription drug abuse. The focus of the office will be to focus on "pill mills" and not doctors who legitimately treat patients for chronic pain.

The AMCNO was involved in the prescription drug task force last year which evaluated many of the issues contained in this legislation. The AMCNO has sent a letter of support to the legislature with regard to the provisions contained in HB 93.

The AMCNO continues to track health care-related legislation as it is introduced in the Ohio General Assembly and we will continue to apprise our members on issues of importance to the practice of medicine in the coming months. ■

NORTHERN OHIO PHYSICIAN

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State Representative William G. Batchelder Speaker of the House 69th Ohio House District

Speaker of the Ohio House William G. Batchelder returned to the Ohio House of Representatives in 2007, having previously served in the Ohio House for 30 years. He currently is serving his third consecutive term and was elected by his colleagues to serve as House Speaker during the 129th General Assembly.



Speaker Batchelder graduated from Medina High School in 1960. He later received a bachelor's degree from Ohio Wesleyan University in 1964, as well as a Juris Doctorate from The Ohio State University College of Law in 1967.

Speaker Batchelder has established a long career in practicing and teaching law. He spent 31 years of his professional career at the Williams and Batchelder Law Firm in Medina, Ohio, while serving as an adjunct professor of law at the University of Akron

Law School and as an adjunct professor at Cleveland State University Levin College of Urban Affairs. Additionally, Representative Batchelder has served as a judge for the Medina County Common Pleas Court, a judge on the Ninth District Court of Appeals from 1999 to 2005, and as a presiding judge on the same court of appeals from 2000 to 2001.

During his tenure at the Ohio House, Speaker Batchelder has been recognized numerous times with the Watchdog of the Treasury Award. He also received the 4-H Meritorious Service Award and the Friends of 4-H award.

The Ohio State Volunteer Firefighters' Association recognized his service to Ohio Firefighters throughout his career. For outstanding contributions to the wise use and management of the nation's natural resources, Speaker Batchelder received the Conservation Legislators Award from the League of Ohio Sportsmen and the National Wildlife Federation.

Speaker Batchelder is a member of the Ohio Farm Bureau, Medina County Township Association and the Grange. He is also a Lifetime Member of Vietnam Veterans of America, the American Legion and Amvets. Representative Batchelder currently serves as a member of the Board of Governors of the Masonic Learning Center for Children, an organization that treats children with dyslexia. He is also an active participant in the Scanlon Inn of Court.

Speaker Batchelder represents the 69th House District, which includes portions of Medina County. He currently resides in Medina with his wife, Alice. They have two children and three grandchildren. ■

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ICD-10 Straight Talk: Overview

By Angela "Annie" Boynton, BS, RHIT, CPC, CCS, CPC-H, CCS-P, CPC-I, CPC-P, CPC-I

As a result of a final rule published on January 15, 2009 by the Department of Health and Human Services (DHHS) under the Administration Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), all covered entities (including healthcare providers, health plans and healthcare clearinghouses) are required to comply with new code set regulations regarding the International Classification of Diseases, 10th Edition (ICD-10) for all covered electronic transactions for dates of service on and after October 1, 2013.

The new code set regulations address usage for the following:

- Clinical Modifications (ICD-10-CM) Diagnosis Code Set
- Procedure Coding System (ICD-10-PCS) Procedure Coding System.

ICD codes are used to classify diagnoses and inpatient procedures and are one of the fundamental elements of healthcare reimbursement. The conversion to the ICD-10 code sets represents a significant change to the coding structure and will have impacts in a majority of business processes and systems as well as require significant training and updates to numerous medical policies and contracts. These changes will be felt across all types of health care providers, facilities and payers.

Diagnostic codes are used across inpatient and outpatient service settings to establish medical necessity, to trigger benefit/coverage determinations and to aide in many quality reporting initiatives. It is a gross misconception for outpatient providers and facilities to think that they will not have to deal with ICD-10 codes in the future.

Preparing for the single largest healthcare change the United States has ever seen is no small task. The longer ICD-10 implementation planning is put off, the harder it will be to comply by the mandate. It has been said over and over again by industry experts, but it is a message that bears repeating: those who wait until the last minute to prepare for ICD-10 are risking their revenue in 2013 and beyond. The risks are tangible, in the form of payment delays and rejected claims; the only way to mitigate these risks is to be fully compliant with ICD-10 by the October 1, 2013 mandate. It is an industry accepted fact that revenue will be impacted to some extent. It will take significant resources, time, and planning in order to adequately achieve compliance, and mitigate any revenue impacts.

There is much work to do in order to prepare for ICD-10: communications, budgeting, training, staffing, IT systems, vendor discussions, business associate issues, trading partner testing, and 5010 implementation are just a few of the areas of concern. Let's discuss a few things practices can do to get the ball rolling toward ICD-10 compliance.

Plan for the ICD-10 Transition:

Organize those responsible for ICD-10 implementation in your practice or facility; form an implementation leadership team. Clearly establish who is going to lead the overall implementation effort. Having a clear "chain of command" will help the implementation process.

There is great benefit in conducting an impact assessment, and for a smaller organization it may be as simple as asking "how are ICD-9 codes used today?" Once these areas are identified, it will be easier to see where remediation efforts need to be focused. Having a plan and timeline on paper for the ICD-10 implementation team will help make the process move more smoothly.

Recognize the Documentation Impacts:

In many practices the biggest hurdle in the ICD-10 implementation process will be how to handle the vast new documentation requirements needed for accurate ICD-10 code selection and reimbursement. It is strongly recommended that documentation efforts begin as early as possible. This can be done by performing simple documentation audits comparing ICD-9 coding and documentation with its ICD-10 counterpart and taking note of the gaps.

In its entirety, the ICD-10 code set has just over 155,000 codes. That is significantly more than the 18,000+ codes we use in ICD-9. Much of the reasons for this great expansion are due to the fact that ICD-10 codes are incredibly specific and much more granular than anything we use today.

For example, compare the codes representing "complications of foreign body accidentally left in body following a procedure."

ICD-9 has one code:

998.4, Foreign body accidentally left during procedure, not elsewhere classified.

ICD-10-CM has 50 codes, here are a few examples:

T81.530, Perforation due to foreign body accidentally left in body following surgical operation.

T81.524, Obstruction due to foreign body accidentally left in body following endoscopic examination.

T81.516, Adhesions due to foreign body accidentally left in body following aspiration, puncture or other catheterization.

Note the specificity in the code descriptions as identified by the underlined terms. When comparing the codes in this manner, it is important to consider what the documentation will need to reflect in order for a coder to accurately select a code.

ICD-10 Training:

Training can easily be the largest part of any ICD-10 implementation budget. It is important that as early as possible a training plan is developed. A critical point of concern in accepting the fact that there is a significant difference between implementation training and code set training, and when to provide each type of training.

Implementation training is more commonly seen in larger group practices and organizations that have teams of people responsible for the ICD-10 transition and it is given early-on. Implementation training is offered by several industry organizations, like the AAPC (American Academy of Professional Coders), though implementation training is a good introduction to anyone interested in learning about the complexities involved with ICD-10 implementation.

Code set training provides detailed knowledge of the code sets. This is the training that coders will need in order to stay current with the ICD-10 transition. Since ICD-10 is formally divided into two separate and distinct code sets, identification of which code set (ICD-10-CM or ICD-10-PCS, or both) and the timing of the training will be critical in any implementation plan.

Training coders too soon could be a costly risk. In order for coders to be proficient, they must use a code set regularly in order to keep their skills. It is unwise to train coders too far out, lest they forget, and ultimately require retraining. CMS recommends training coders 6-9 months ahead of the ICD-10 implementation date, and ensuring that coders have continual practice throughout 2013. This timeline will obviously vary given the specialty, setting, size of the organization, and the number of coders that require training. Planning and budgeting for a strategic training plan will help to mitigate productivity losses as a result of training. Furthermore, ICD-10 training is intensive. Do not underestimate the amount of time coders will likely need to become fully proficient in ICD-10, plan for 20 hours for outpatient coders learning the diagnostic set (ICD-10-CM) and 50 hours for inpatient coders learning both the diagnostic and procedure sets (ICD-10-CM/PCS).

(Continued on page 12)

ICD-10 Straight Talk: Overview

(Continued from page 11)

Avoiding ICD-10 will not make it go away. It will make the process more costly, more difficult, more resource intensive, and more stressful. The only sure way to lessen the costs associated with ICD-10 implementation is to understand the impact that implementation will have on your organization. There will be revenue impacts across all settings, provider, facility, vendor and payer alike. Physicians, practices, and facilities that do not adequately prepare for ICD-10 risk not getting paid for the services they render. The best advice is to start implementation planning now, the longer it is put off the harder and more costly it will be.

Annie Boynton is a multi-credentialed coder and the Director 5010/ICD-10 Communication, Adoption and Training for UnitedHealth Group. She is an adjunct faculty member at Massachusetts Bay Community College and is a developing member of the AAPC's ICD-10 Training team. Annie frequently speaks and writes about coding matters, including ICD-10 and 5010 implementation.

Editor's Note: The AMCNO has partnered with Tri-C to offer discounted practice management and coding classes to our members. For more information on these classes please see our web site at www.amcnoma.org or look for more information in our publication for practice managers "Practice Management Matters". ■

Registration for the EHR Incentive Program Now Available

All eligible professionals, hospitals and critical access hospitals must register to participate in the electronic health record (EHR) incentive program. Registration for the Medicare program began at the beginning of January 2011. The Medicaid EHR incentive programs can also begin in 2011, but the actual start dates vary by state.

IN ORDER TO REGISTER, PHYSICIANS WILL NEED TO HAVE ENROLLMENT RECORDS IN THE APPROPRIATE SYSTEMS, INCLUDING:

National Provider Identifier (NPI)

- All EPs must have an NPI in order to participate in the Medicare and Medicaid EHR incentive programs.

National Plan and Provider Enumeration System (NPPES)

- Most providers will need an active user account with the National Plan and Provider Enumeration System (NPPES.)

Provider Enrollment, Chain and Ownership System (PECOS)

- All eligible Medicare professionals must have an enrollment record in PECOS to participate in the EHR incentive programs. Eligible professionals who are only participating in the Medicaid EHR incentive program are not required to be enrolled in PECOS.

To obtain information from the Centers for Medicare and Medicaid Services (CMS) on the registration and attestation process go to: http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

The AMCNO is also working with the Ohio Health Information Partnership (OHIP) on EHR initiatives. OHIP has additional information available online regarding the registration process. To view this information go to: <http://ohiponline.org/Pages/EHRIncentiveProgram.aspx>

To begin the registration process go to: <https://ehrincentives.cms.gov/hitech/login.action>

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AMCNO BOARD ACTIVITIES

AMCNO Board of Directors Endorses the National Children's Study

The AMCNO is excited to announce our endorsement of the National Children's Study (NCS). This is a historic National Institutes of Health (NIH) funded research study sponsored by the National Institutes of Health, the Centers for Disease Control and Prevention, and the Environmental Protection Agency. It is the first large-scale observational study aimed at understanding the role of prenatal and childhood environmental exposures and genetics which together influence lifelong health, development, and disease. This landmark study will eventually follow 100,000 children from the time their mothers are pregnant until age 21 years. The results could improve children's health for generations.

Cuyahoga and Lorain Counties are two of the 105 counties selected nationwide to be a part of this study, and Case Western Reserve University is heading the research locally. Over the next four years, CWRU will enroll women who are pregnant or are planning a pregnancy in the near future. AMCNO President, **Dr. Laura David**, is representing the AMCNO in this initiative. If you, or a member of your office staff would like to schedule a meeting to discuss being directly involved in making the National Children's Study a success, please call 216-881-0382. Over the coming months, representatives from the study will be making contact with practices to answer questions and drop off information for patients. ■

AMCNO Voices Support for HR 5 – The "HEALTH" Act

House Republicans have introduced medical liability reform legislation that would cap damage awards. The Help Efficient, Accessible, Low-cost, Timely Health Care Act of 2011 would limit noneconomic damages to \$250,000, and punitive damages to the greater of \$250,000 or twice the amount of economic damages. It would not preempt state laws that establish higher or lower damage limits.

Rep. Phil Gingrey, MD (R, Ga.), an obstetrician/gynecologist, sponsored the bill as a replacement for the health reform law because he said the legislation would save billions of taxpayer dollars by reducing defensive medicine. The HEALTH Act also would set a statute of limitations on filing health care lawsuits of one year after a patient discovers — or should have discovered — an injury, or three years after the injury, whichever occurs first. The bill is modeled on liability reforms that have been on the books in California since 1975. The House has adopted previous versions of the measure numerous times during the past decade, but the Senate has never followed suit.

Many organizations support the bill, including the AMCNO. In the AMCNO's letter to Dr. Gingrey, the AMCNO President, **Dr. Laura David** said that "defending a medical liability claim is expensive and long, taking an average of five years to resolve. Statistics have shown that more than 60 percent of liability claims against physicians are dropped, withdrawn or dismissed without payment." However, even these types of cases have a price — according to the Ohio Department of Insurance the average cost to defend a medical liability claim in Northern Ohio was \$35,429.00 in 2009.

In his Jan. 25 State of the Union address to lawmakers, President Obama said he would be open to considering "medical malpractice reform to rein in frivolous lawsuits" but did not elaborate. He previously has acknowledged the problem of defensive medicine costs and frivolous lawsuits, but repeatedly has said he opposes caps on damage awards. *(At press time, a companion bill had been introduced in the U.S. Senate- S 218).* ■

AMCNO Appoints Representative to the Northeast Ohio Quality Council

The AMCNO board of directors was pleased to accept a position on the Northeast Ohio Quality Council — an integral part of the Northeast Ohio Quality Collaborative. AMCNO President-Elect, Dr. Lawrence T. Kent will represent the AMCNO on the Council. The Ohio Hospital Association (OHA)-based 34-hospital collaborative, the Northeast Ohio Quality Collaborative, in partnership with the Akron Regional Hospital Association, was established in 2007, and began working on data processing, risk adjustment models, data reports and the collaborative structure. To date, this group of hospitals has demonstrated a nearly 20 percent improvement in performance for pneumonia care.

Prior to the establishment of the collaborative (fourth quarter, 2006) Northeast Ohio's participating hospitals were providing all of the recommended pneumonia treatment to 62 percent of the areas patients. By the third quarter of 2008, nearly 82 percent of patients were receiving all of the appropriate care and treatment. Currently, this collaborative is evaluating opportunities to reduce 30-day readmission rates for heart failure patients, which is a common and costly occurrence for hospitals. For more information regarding the collaborative go to: http://www.ohanet.org/Narrative/Northeast_Ohio_Quality_Collaborative ■



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AMCNO COMMUNITY ACTIVITIES

Dr. Laura David, AMCNO President, Appears on WKYC to Address the “Changing Face of Healthcare”

Dr. Laura David, president of the AMCNO, was invited to interview on a recent WKYC “In Focus” segment to discuss how local doctors and patients are taking a new look at how care is delivered in our community. The interview addressed recent reports which have shown that health care reform is impacting small physician practices — with some studies showing that more physicians are joining group practices or aligning with large systems to cut costs by combining administrative and technical resources. Others are opting to work part time or are walking away from their medical careers because they are frustrated by regulations, smaller insurance reimbursements, high costs and liability. Another trend, concierge medicine, has begun to surface in some parts of the country with physicians seeing limited numbers of patients who pay annual or monthly fees.

Dr. David noted that running a small private practice is like running a small private business and it can be quite challenging with the cost of liability and malpractice insurance and the general costs associated with running a business. Reimbursements have continued to go downward as costs and reimbursements are adjusted to the Medicare and Medicaid levels. In addition, she cited generational factors as one of the reasons physicians are joining large

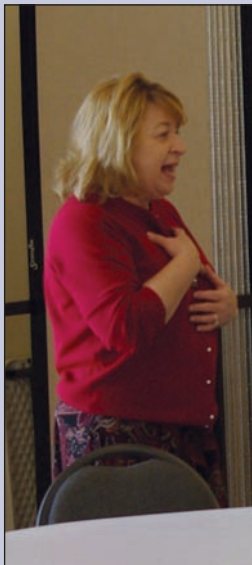
groups. She noted that many young physicians who are trained in hospitals and who have limited shifts and are used to the resources of a big hospital with billing, accounting, always having supplies available etc., want to step right out into a similar practice setting without incurring a lot of debt.

Dr. David briefly addressed concierge medicine noting that it is a small movement in the country and it may be an answer for



Dr. David spends a moment on the set at the WKYC news desk (left to right – Dr. Laura David, AMCNO President, Monica Robins, and Eric Mansfield.)

some patients with specific needs. To view Dr. David’s entire interview go to: http://www.wkyc.com/news/health/health_article.aspx?storyid=168368&catid=7 ■



*In February Dr. Laura David, AMCNO President was invited to present to a women’s church group on the topic of menopause. Dr. David’s comments were very informative and the group asked a variety of questions. **Editor’s note:** The AMCNO Speakers Bureau provides organizations and groups with physician speakers on a variety of topics. The AMCNO is always looking for physicians interested in becoming a part of our Speakers Bureau. If you are interested in getting involved, please contact Cindy Penton at the AMCNO offices at 216-520-1000, ext. 102.*



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Regulating the Medical Workplace in the World of Web 2.0

Policies for Facebook, Twitter, Blogs and Other Social Media Postings are a Must

By Susan Keating Anderson
Walter & Haverfield LLP

In a few short years, social media has gone from fad to fact. Facebook and Twitter, the two most widely recognized social media vehicles, in addition to the countless number of other social media sites, online forums, chat rooms and weblogs (aka blogs), have become indelibly woven into the fabric of daily life – both personal and professional - at a rapid-fire pace. American adults are “Facebooking,” “tweeting” and blogging not just at home, but also at the office during work hours, using work-owned equipment, and sometimes, discussing work issues, for good and bad.

Consider the following statistics. A study conducted by Pew Internet & American Life reveals that more than 57 million Americans read blogs. A Nielsen study reveals that in 2009, U.S. internet users spent about 16 percent of their online time on social networking websites and about 12 percent of the time e-mailing. By 2010, the social networking time increased to 23 percent, while e-mailing dropped to 8 percent. The Pew study also revealed that 75 percent of Facebook users admit to checking their Facebook page while at work.

Aided by the advent of widespread WiFi, PDAs and other smartphone devices, access to social media is also becoming easier for all age ranges. In fact, Nielsen found that the number of Americans aged 50 and older who visit social media sites is twice that of the 18 years and younger group. Simply put, social media isn't just for kids anymore and, because of that, it has found its way into the modern workplace – medical practices and hospitals included.

So what does the proliferation of Facebook, Twitter, blogs and other methods of social networking and communication mean for Northeast Ohio physicians? Like employers in other industries, physicians face a multi-faceted issue: how to implement and regulate their own presence in the social media marketplace (personal and professional) as well as that of their employees (again, in both the personal and professional realm).

This issue presents a proverbial minefield of legal and ethical hazards for today's physician – not to mention potential civil or criminal liability – if the murky waters of this dynamic, instantaneous communication method aren't navigated carefully.

Presenting a professional (and legal, and ethical) social media presence

Social media provides the opportunity to reach potentially millions of people to share information easily, quickly and efficiently. It's no wonder that physicians have begun to turn to Facebook, Twitter and blogging, as well as other social media vehicles specific to the medical field, as a way to establish a presence and reputation online.

If used correctly, social media can be a valuable tool for a medical practice, giving doctors an accessible outlet to connect with peers nationwide without leaving their office and a way to market their practice and expertise and disseminate public health information to a wider audience. However, pitfalls can arise when a physician's postings, or that of the physician's employees, crosses over to the realm of inappropriate, illegal or unethical.

Applicable laws

In determining what is and is not appropriate for dissemination by a physician-employer through social media, the myriad of laws that could potentially reach a physician's online communications must be considered. Perhaps most obvious is the responsibility to guard patient privacy under HIPAA and, in Ohio, under the more stringent privacy protections arising from the Ohio Supreme Court case *Biddle vs. Warren General Hospital*, 86 Ohio St.3d 395, and its progeny.

In a broader context, the same laws and regulations that apply to the everyday work environment also apply online. Thus, physician-employers have to be cognizant in their online communications of the possible application of laws such the federal Title VII of the Civil Rights Act of 1964 (applicable to employers of 15 or more employees) and Chapter 4112 of the

Ohio Revised Code (applicable to employers of 4 or more employees). These laws prohibit discrimination based upon such things as race, color, sex, religion and other protected classes. Similarly, federal laws such as the Americans with Disabilities Act (ADA), the Age Discrimination in Employment Act, the Pregnancy Discrimination Act (and comparable Ohio Ohio laws), and the more recent Genetic Information and Non-Discrimination Act (GINA) of 2008 could apply.

In the context of regulating employee use of social media inside and out of the workplace, privacy issues are again paramount, but in a somewhat different context. In *Housh v. Peth*, 165 Ohio St. 35, the Ohio Supreme Court established the tort of invasion of privacy as including “the wrongful intrusion into one's private activities in such a manner as to outrage or cause mental suffering, shame or humiliation to a person of ordinary sensibilities.” This case has been used by employees to bring invasion of privacy claims against their employers for things like accessing an e-mail sent through or held in a business e-mail account, monitoring employee internet usage and accessing employee blogs and social media postings. In addition, depending on the context and conduct involved, either or both of the following two laws could apply. These are the federal Electronic Communications Privacy Act, which prohibits the unauthorized interception of wire, oral or electronic communications and the Stored Communications Act, which makes it illegal to “intentionally access a facility through which an electronic communication service is provided...and thereby obtain...access to a wire or electronic communication while it is in electronic storage in such a system.” 18 U.S.C. § 2701.

Finally, and, importantly, physician-employers should take heed from a recent National Labor Relations Board (NLRB) complaint dealing with social media. In November 2010, the NLRB charged American Medical Response of Connecticut, Inc., an ambulance company, with improperly terminating an employee for making negative comments on her Facebook page about her supervisor. The NLRB claimed that the employee was terminated for engaging in protected concerted activities by criticizing her supervisor to other employees.

While the case was settled between the parties in January, the complaint signals a

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Regulating the Medical Workplace in the World of Web 2.0

(Continued from page 15)

focus by the NLRB on an employer's regulation of employee's social media posting when such regulations arguably restrict an employee's right to engage in concerted activity protected under the National Labor Relations Act (NLRA). I don't have to worry about NLRA because I'm not a union employer, you say? Think again – the NLRA's protection of concerted activity applies to non-union workplaces too.

Physician use of social media

So what is a physician to do, or not, with respect to his or her own social media use? First, physicians should not rely upon the false security of "privacy settings" that may or may not actually protect the data posted to social media sites. As a result, doctors must think carefully before they accept patients as a "friend" on site like Facebook or allow an open "following" on a Twitter page. Even if they are careful about who they accept as friends or have what they believe to strict privacy filters in place, their posts may still be passed along to other people or otherwise accessed by unintended recipients, creating a documented trail that can be used in potential litigation or audits down the road.

For the same reasons, physicians who are creating pages on social networking sites would be best served to create a personal page for non-professional interaction with family and friends and a separate page for use solely in their practice where they can maintain appropriate professional, ethical boundaries of the patient-physician relationship as they would in any other context. No matter how the pages are constructed, however, it cannot be stressed enough that when it comes to communications online, physicians must be vigilant to maintain the required standards of patient privacy and confidentiality at all times when communicating and conveying information.

Additionally, it's important to remember that providing advice online also creates a documented trail of communications that may exist in perpetuity. If a physician's "Facebook friend," who is not a patient, asks a health-related question online, the ramifications of responding can be quite different than if the physician has a casual, in-person discussion with the friend on the topic. In a worst case scenario, the documented exchange on Facebook could be used as evidence of a physician-patient

relationship in a courtroom or before many regulatory bodies.

Finally, if other employees of the practice are permitted or required to post and otherwise maintain the content of a physician's social media site, it is recommended that policies setting forth the parameters of this responsibility or discretion be created and the relevant employees trained on those policies. Since it is the physician's name and medical reputation at stake, it is also imperative that the physician him or herself monitor the postings and follow-up on questionable or inappropriate content.

Developing an effective social media policy for employee use

Beyond carefully developing and maintaining their own social media presence, physician-employers face a second challenge – monitoring their employees' presence on social media as it relates to the workplace.

While physician-employers do have the right to monitor employee personal internet and e-mail usage, particularly when the employee is using equipment owned by the practice or hospital and engaging in such activity during work hours, it is highly recommended that physician-employers have written policies in place that inform employees of the parameters of this monitoring. Such policies should include a clear, direct statement that employees should have no expectation of privacy in their use of practice-owned equipment, e-mail accounts, internet providers, or software.

Specific to social media, the issue gets a little muddier because employee posts to social media often, but not always, occur outside of work hours and are arguably personal in nature, even if the postings address practice-related issues. Despite this, employers do have the right to regulate such postings within the context of the potential effect on the workplace and practice.

Again, it is important that there be a written social media policy in place, which should include *but not be limited to* the following provisions:

- Prohibit the use of employer-related information of any kind in employee postings;
- Prohibit the disclosure or use of any sensitive, proprietary, confidential or financial information about the practice, hospital or any of its patients;

- Prohibit the employee from implying the endorsement of the practice or hospital in any statement or posting;
- Prohibit the employee from posting material that is obscene, defamatory, libelous, threatening, harassing, abusive, or hateful about the practice or hospital, its physicians, employees or patients; and
- Inform employees clearly that violations of the policy may result in discipline, up to and including termination of employment.

The social media policies should also be tied in to other policies, such as harassment, discrimination and acceptable-use policies.

Equally important to maintaining written policies is taking the time to train practice employees on the policies. Employees need to realize that what is unethical, unprofessional and even illegal in the office environment also holds true online and that their posts, even if intended to be private or personal in nature, could result in civil liability or other legal consequences.

Going forward in the social realm

Without a doubt, social media presents an efficient, effective and immediate way to share information with colleagues, peers, employees and patients and can help promote a medical practice in ways that reach beyond traditional marketing and advertising.

As the countless number of Facebook indiscretions reported in the news reflect, however, it's easy to forget that what is posted online, even if protected by so-called "privacy settings" is rarely anonymous and is easily shared, searchable, and generally permanent. For that reason, physician-employers must recognize that their actions online, as well as that of their employees, could negatively affect their reputations, practice and careers and lead to significant legal consequences.

Physician participation in social media should be approached with care and common sense, whether the site is a wide-reaching one such as Facebook or one of the many sites specific to the medical community. Likewise, the same care and common sense needs to be applied in the workplace by developing social media policies for employees of a medical practice or hospital setting. With a little bit of thought and effort, modern medical practices and hospitals can reap the benefits of the ever-evolving World of Web 2.0. ■

Maintenance of Licensure: Medical Regulation with a Sheathed Sword

By Richard A. Whitehouse
Executive Director – State Medical Board of Ohio

In May, I mark my sixth anniversary as executive director of the State Medical Board of Ohio. Looking back, I particularly recall my second week on the job attending the annual meeting of the Federation of State Medical Boards (FSMB) in Dallas, Texas. The FSMB is made up of 70 member medical boards across the country and is a resource for best practices and regulatory innovation.

On this, my first excursion as a new executive, I eagerly participated in sessions regarding “Just Culture” and the notion espoused by Harvard Professor Dr. Lucian Leape that “the single greatest impediment to error prevention in medicine is the fact that we punish people for making mistakes.” As someone with a background in economics, I was impressed by the graphic of a horizontal line across an XY axis illustrating a “nominal level of competence” and a parabolic line that demonstrated a physician’s level of knowledge and skill throughout a career from medical school through retirement. “What happens when that line intersects with the horizontal line?” someone asked. “Well,” said the facilitator, “that’s where your patient complaints come from.”

As a devotee of *The Art of War* by Chinese warrior/philosopher Sun Tzu, I occasionally consider the application of military strategy to the medical board’s mission of protecting the public through effective medical regulation. Sun Tzu taught that excellence in warfare was achieved with the sheathed sword — without resorting to battle.

For regulators, the “sword” is the disciplinary process. But, our “war” is not against those physicians we license. It should be against a system that is designed to assign blame only after an adverse event occurs. In my view, ensuring the ongoing competency of physicians is a way to accomplish our mission of public protection pro-actively rather than to simply wait to wield the sword of discipline.

I have too often experienced the frustration of witnessing the patient harm associated with the loss of a physician’s once promising career. It is in no small part a result of confining ourselves to a regulatory system that merely picks up the pieces, assigns blame, and simply moves on to the next case. So, this initial experience with the

FSMB got me thinking. Can we as medical boards do more to ensure the physicians we license never fall below the line of nominal competence thereby causing us to unsheathe our disciplinary sword? Can we, even as regulators, do more to push the parabolic line even further out?

Ohio has a robust system of medical regulation on the polar extremes of initial licensure and disciplinary action. But, between the poles lie a great void and only the presumption of continued competence. Applicants for initial licensure are required to meet high professional standards as demonstrated by education, credentials, and training. Once licensed, only a minority of individuals are included in the 4,000+ complaints received by the medical board in one year. But, many of these actions involving human and systems-based errors — and often patient harm — could be avoided through efforts to ensure continued competency. Such an approach is more appropriate than using the sword properly associated with addressing more reckless behaviors. We need a better system of regulating the practice of medicine to address these cases if we are to save both patient lives and professional careers.

State medical boards have not done enough in this regard — until now. Historically, it has been the norm for regulators to stand idly by waiting for circumstances that call upon us to unsheathe the sword and impose traditional disciplinary measures only after patient harm occurs. However, the aftermath of such a system, while celebrated in the ranking of “tough” medical boards, leaves patient harm and lost careers in its wake. Certainly, any new idea that has the potential to avoid such an outcome presents us with a moral imperative.

State medical boards and the medical profession are facing an increasing demand for greater accountability and transparency.

Despite these new buzzwords, the pressure for regulators to do more is not itself a new phenomenon. Reports from the Institute of Medicine have long called for dramatic changes in the U.S. health care system. The landmark *To Err is Human* report challenges health professional regulatory boards to improve patient safety by periodically re-examining and re-licensing providers “based on both competence and knowledge of safety practices.”

In 2004, the FSMB House of Delegates issued a policy statement suggesting “[s]tate medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking re-licensure.” That statement calls upon all medical boards to do more to ensure the system of regulating physicians addresses issues related to human and systems-based error rather than standing by only to unsheathe the sword of discipline and assign blame once things have gone wrong.

Currently, Ohio and other medical boards rely upon continuing medical education as a mechanism to ensure some semblance of continued competency. But, this alone is not enough as there may be no relationship between the CME taken and the actual nature of the physician’s practice. Beyond this, the best that medical boards have offered in augmenting their regulatory efforts are complaint-driven programs limited to quality intervention, remediation, or rehabilitation. But, these efforts are still only reactive to events that would be avoidable if greater efforts are focused early on to ensure ongoing competency.

Clearly, medical regulation in the 21st century must be about more than simply licensure and discipline. Ohio has been a leader in rehabilitative and remediation programs that bring greater public value to the work of medical regulation. But, we

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STATE MEDICAL BOARD ACTIVITIES

Maintenance of Licensure: Medical Regulation with a Sheathed Sword

(Continued from page 17)

need to do even more to provide the public with meaningful assurance that licensure renewal does indeed connote continued competence. Ohio and state medical boards across the country are currently embracing a new approach to ensure that physicians can better fulfill this professional obligation in a manner transparent to the public.

Maintenance of Licensure (MOL) is a system in which physicians periodically demonstrate ongoing clinical competence as a condition of licensure renewal. In December, the State Medical Board of Ohio formally resolved to support the MOL concept and determine the necessary steps to become a pilot state for implementation. MOL involves three components to demonstrate the ongoing competency of physicians. Each of these components would in turn contain an array of items that would meet the requirement for licensure renewal.

The first component is "reflective self-assessment." This component requires that physicians ask themselves what improvements they can make to their practice. Physicians would participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent completion of tailored educational or improvement activities. Items meeting these criteria include the review of literature, home study, web-based study, CME, or MOC/OCC certification. For most, this is nothing new. And, in fact, the MOL Implementation Group suggests that physicians who are board certified may already meet all three components of MOL.

The next component is "assessment of knowledge and skills." This component requires physicians to determine on their own "what they need to know" to improve their practice. Physicians must demonstrate the knowledge, skills, and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice. This can be accomplished through patient and peer surveys, computer-based simulations, and practice relevant MOC/OCC examination.

The final component involves measurement of actual "performance in practice." This

component challenges physicians to assess exactly "how they are doing." Physicians would demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement. Examples include 360 degree evaluations, analysis of practice data, and patient review.

The FSMB Guiding Principles underlying the integration of MOL into the process of licensure renewal include:

- supporting a commitment to lifelong learning and facilitating improvement in physician practice
- establishing requirements that are administratively feasible and developed in collaboration with other stakeholders
- ensuring patient care is not compromised or barriers to physician practice created
- creating a flexible infrastructure with a variety of options for meeting requirements
- balancing transparency with privacy protections

I am a member of a small group selected by the FSMB and charged with the development of a template that state medical boards may follow to implement their own state's vision for MOL. What MOL will exactly look like in Ohio is yet to be determined. But, as we move in the direction of adopting the MOL concept in Ohio, I will be speaking to physician groups and associations to address their questions and solicit their input.

MOL represents a sea change in the approach of medical boards to medical regulation. It is a means for them to play a new role in ensuring a stable workforce of competent practitioners in the health care workplace. But, it will not happen overnight. In fact, MOL is recommended to be phased in by states incrementally over a ten-year period.

Many questions are yet to be resolved in the development of the MOL concept and some of these must necessarily be resolved by state medical boards. These include how MOL will apply to older physicians; whether nonclinically active physicians with active licenses must comply; and what physicians with inactive licenses must do to meet MOL requirements upon reentering

active practice. One thing is certain. MOL must be implemented in a manner that is neither onerous to physicians nor deleterious to the health care workforce. Successful implementation of this plan will be defined by the degree to which it actually assists a physician's practice and avoids the need for disciplinary action by the medical board.

If the best outcome in battle is achieved without unsheathing the sword, so too should medical boards strive to achieve their goal of public protection in such a manner as to avoid the disciplinary battle whenever possible. Among other things, this means doing more to ensure the ongoing competency of physicians to avoid human and systems-based errors. MOL accomplishes this thereby saving the sword of discipline for cases of reckless behavior. It is a better approach to protecting the public and preserving the integrity of the medical profession.

Comments welcome at richard.whitehouse@med.state.oh.us.

More information is available at the following sites:
FSMB-MOL <http://fsmb.org/mol.html>
MOL Frequently Asked Questions <http://fsmb.org/pdf/mol-faqs.pdf>

Editor's note: *The AMCNO board of directors was pleased to host Mr. Whitehouse at their January meeting. The board expressed a variety of concerns to Mr. Whitehouse with regard to the maintenance of licensure concept. Specifically, the AMCNO board raised concerns relative to the need for the state board to implement this new licensure process and asked Mr. Whitehouse if the state board could produce statistics and data that this change was warranted. The AMCNO board also commented that physicians are already beleaguered with enough rules and regulations without adding additional paperwork and forms to the licensure process. The AMCNO plans to monitor the progress of this initiative going forward. If any AMCNO member has specific concerns or comments about the MOL please make your comments/concerns known to both Mr. Whitehouse and the AMCNO Executive Vice President, Ms. Elayne Biddlestone at ebiddlestone@amcno.org. ■*



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AMCNO MEMBERSHIP ACTIVITIES

Wine Tasting

AMCNO members, residents, and spouses/guests attended this year's wine tasting event on Valentine's Day eve, Sunday, February 13th at La Cave du Vin. Upon arrival, guests were greeted with a nice light Vincenzo Toffoli Prosecco. Throughout the evening members and guest enjoyed red and white wines from several different regions of the world.

The venue provided the perfect atmosphere to mingle with fellow AMCNO members and their guests...we will be doing it again next year, watch for information!



Having a great time with the wine (left to right, Dr. Bijan Eghstesad, Mrs. Susie Seitz, Dr. Victor Bello, and Dr. William Seitz)



All smiles for the camera are (left to right) Mrs. Lorene Bastulli, Mrs. Anne Hirsch, and Mrs. Anne Rogoff



Chatting over a glass of wine are (left to right) Dr. Irving Hirsch, Dr. Robert Rogoff, Dr. John Bastulli and Dr. Robert Stern



Toasting the evening are (left to right) Dr. Maria Shaker, Mr. Kal Zucker, Dr. Mary Haerr, Dr. Thomas Murphy and Dr. Laura David



Dr. and Mrs. Gleb Moysaenko share a moment at the wine tasting



Dr. James Sechler, Dr. Victor Bello and Mrs. Veronika Sechler spend a moment during the event

SAVE THE DATE

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

invites you to attend our
2011 Annual Meeting

Friday, May 6, 2011

Ritz-Carlton Cleveland • 1515 West Third Street
6 p.m. Reception • 7 p.m. Dinner
Black Tie Optional

Presentation of 50 Year Awardees and
Academy of Medicine Education Foundation
(AMEF) Scholarships to medical students from
Case School of Medicine, Cleveland Clinic
Lerner College of Medicine,
The Northeastern Ohio College of Medicine and
Ohio University College of Osteopathic Medicine

AMCNO 2011 Honorees

C. Martin Harris, MD

John. H. Budd
Distinguished Membership Award

Michael L. Nochomovitz, MD

Charles L. Hudson MD
Distinguished Service Award

Marvin D. Shie III, MD

Clinician of the Year Award

Mary Jo Hudson, Esq.

Special Recognition Award

Timothy F. Hagan

Honorary Membership Award

Amy S. Leopard, Esq.

AMCNO Presidential Citation Award

*Please join us in congratulating our
medical scholarship recipients and
awardees on May 6, 2011.*