

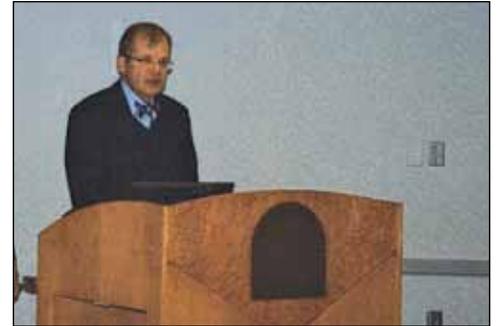
AMCNO Participates in Patient Navigation Collaborative Event

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) president, Dr. James L. Sechler was on hand to welcome participants to a session entitled "Leading the Way; A Panel Discussion on the Value of Patient Navigation." The session was convened by the Northeast Ohio Patient Navigation Collaborative (NEOPNC). The Center for Health Affairs (CHA) and the AMCNO recently formed the collaborative which includes representation from hospitals and community organizations from across the region. The collaborative is committed to creating awareness of and access to healthcare resources throughout northeast Ohio by creating a network of patient navigation services.

The NEOPNC session was held at Southwest General Health Center and the panel discussion was moderated by Ms. Mary Weir-Boylan from MetroHealth Medical Center. Presenters included Dr. Harold P. Freeman, the founder of the patient navigation concept, Ms. Dee Dee Ricks, an advocate for patient navigation, Mr. Bill Ryan from the

CHA and representatives from area hospitals and insurance companies. Ms. Carol Santalucia, who is working with the CHA on the patient navigation project, also participated in the event.

Dr. Freeman outlined several of the principles of patient navigation noting that patient



Dr. James L. Sechler, AMCNO president, welcomes the participants to the patient navigation session.

navigators keep patient care centered while concentrating on the movement of the patient through the healthcare system. Navigators also remove barriers for the patient in the health care system such as communication or insurance barriers. He commented it is important that the role of the patient navigator
(Continued on page 6)

State Medical Board Votes Against Implementation of Maintenance of Licensure

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) physician leadership was pleased to learn that due to the advocacy efforts of the AMCNO as well as the efforts of other statewide medical associations, the State Medical Board of Ohio (SMBO) has decided not to proceed with a pilot project to implement maintenance of licensure (MOL) in Ohio.

The AMCNO board spent months reviewing the MOL issue before the board of directors voted to oppose the proposed SMBO efforts to impose alternative Maintenance of Licensure requirements on physicians in Ohio.

The AMCNO sent letters to the SMBO voicing our opposition to MOL and our staff began to attend their MOL Ad Hoc Committee meetings to monitor whether or not the SMBO would in fact vote to proceed with the MOL concept.

As the discussions by the SMBO continued the SMBO directed their staff to prepare a plan for the implementation of MOL and submit the plan to the SMBO at their October meeting.

Several days before the October SMBO meeting, the AMCNO joined forces with the Ohio State Medical Association along with ten
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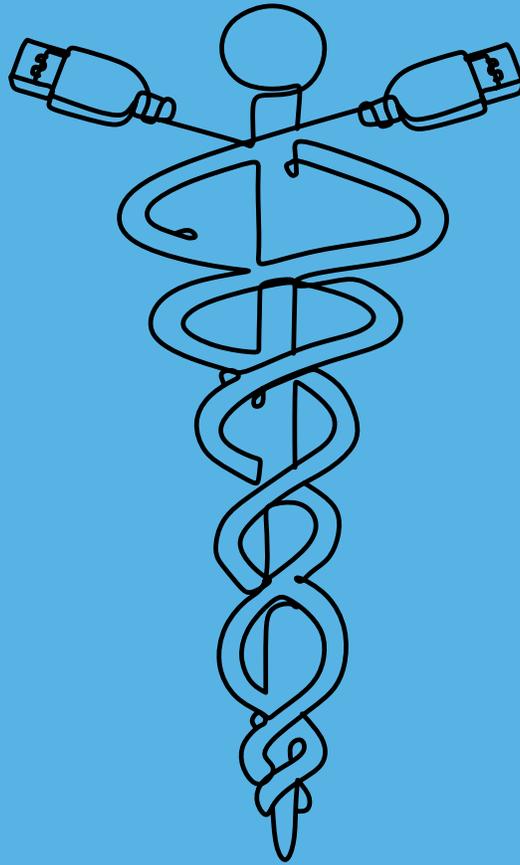
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LEGISLATIVE AND ADMINISTRATIVE UPDATES

State Medical Board Votes Against Implementation of Maintenance of Licensure

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other statewide medical associations and sent a detailed letter to the SMBO reiterating that our physician members were strongly opposed to any efforts by the SMBO to implement different maintenance of licensure (MOL) requirements other than those currently in place for physicians in Ohio. The associations noted that Ohio physicians are already required to participate in 100 hours of continuing medical education (CME) every two years and physicians are already subject to extensive quality measures and data reporting programs aimed at enhancing the level of care provided to patients. In addition, almost all Ohio physicians participate in health plan credentialing, hospital staff credentialing, and government quality measures programs. Physicians are regularly asked to comply with policies and regulations aimed at measuring the quality of care that they are providing. The AMCNO believes that physicians in Ohio are already working hard to prove, and improve, their competency and that requiring physicians to submit to additional medical board regulations regarding competency would be redundant and unnecessary and a waste of SMBO resources.

During their discussion, several members of the SMBO MOL Ad Hoc committee commented that there has been significant pushback from physicians and medical organizations from around the state about MOL implementation. The committee agreed that implementing MOL at this time could have the potential to adversely impact physicians who are already striving to comply with increased government regulations in addition to maintenance of certification and CME requirements.

The decision not to implement MOL in Ohio is a victory for the AMCNO and our members. The AMCNO will continue to monitor SMBO activities on this issue and other issues that could impact our membership.

SMBO Executive Director Resigns

In October, the State Medical Board of Ohio accepted the resignation of Mr. Richard Whitehouse and appointed Ms. Kim Anderson, the SMBO Assistant Executive Director, as the Interim Executive Director.

AMCNO Physician Leadership Meets with State Medical Association Council



Dr. James Sechler, President of the AMCNO, and Dr. John Bastulli, AMCNO Vice President of Legislative Affairs, and the AMCNO Executive Vice President/CEO were invited to meet with the Ohio State Medical Association Council at their meeting in September. The AMCNO and the OSMA already work closely on legislative and advocacy issues and the two organizations are considering if there are other avenues of collaboration that can be explored. AMCNO and OSMA leadership plan to meet again in the near future.

State Medical Board of Ohio Meets with AMCNO to Discuss Increase in Physician Licensure Fees

Physician officers and staff from the SMBO recently met with the AMCNO physician leadership to inform the AMCNO that the SMBO would be seeking a physician licensure/re-licensure fee increase in the next state budget cycle. SMBO representatives noted that there has not been a physician licensure or re-licensure fee increase since 1999 and the SMBO needs to ask for the increase to sustain current operations noting that this would not be utilized to fund new programs. The SMBO budget request would raise its initial physician licensure fee to \$435 and its renewal fee to \$400. The SMBO staff noted that this increase is anticipated to allow the SMBO to continue to operate without future increases to physician fees for at least 10 years. The board's current annual budget is \$9.2 million. Without a fee increase the SMBO would have to reduce its staffing by at least 10% in the next biennium. The SMBO is of the opinion that any reduction in staffing will result in delays in licensure, renewals, enforcement and complaint resolution. The fee increases will give them

an increase in their annual income of \$2 million and provide them the ability to sustain operations where they are now.

The AMCNO requested additional information from the SMBO to justify the licensure fee increases including a breakdown of licensure fees from contiguous states as well as information on how these states ranked nationally with regard to efficiency, regulation and disciplinary actions. It was not clear from the data provided by the SMBO why it is necessary to increase SMBO revenues by \$2.2 million per year to continue current SMBO operations. It was also unclear whether or not the additional funds would be utilized for the development of additional SMBO programs. The AMCNO expressed concern that the proposed fee increases were for physician licensees only and did not affect other SMBO licensees. The AMCNO board of directors objected to this fee increase request and voted not to support the physician licensure fee increase unless the AMCNO receives additional information from the SMBO showing the need for such an increase and how the additional funds would be utilized, and further the

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State Medical Board Votes Against Implementation of Maintenance of Licensure

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AMCNO board recommended that the AMCNO confer and work with the state medical association on this issue, if feasible. The AMCNO has also sent a letter to Governor Kasich to voice our concern about the possibility of a physician licensure fee increase.

Director McCarthy Outlines Medicaid Modernization Plan

Due to the election campaign season, the Ohio legislature has been somewhat dormant; however, Ohio Medicaid Director John McCarthy did provide testimony to the Joint Legislative Committee for United Long-Term Services and Supports which included project updates and a preview of SFY 14-15 budget policy priorities. Mr. McCarthy noted that the Ohio Department of Job and Family Services (ODJFS) had made significant progress on several of their high-priority projects.

In an effort to integrate Medicare and Medicaid services, Ohio submitted its integrated care delivery system (ICDS) proposal to the Centers for Medicare and Medicaid Services (CMS) in the spring of 2012. Ohio chose the capitated managed care model offered by CMS for this purpose. Ohio will develop a care delivery system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including long-term services and supports. Ohio has continued to engage provider associations to discuss outreach and the AMCNO will continue to monitor how this project will roll out in Ohio.

On the issue of health homes, Mr. McCarthy noted that Medicaid has teamed up with the Ohio Department of Mental Health (ODMH) to focus first on health homes for Medicaid beneficiaries with serious mental illness. Care coordination through Ohio's health home proposal will be eligible to claim enhanced federal match to pay for services. This concept is tentatively scheduled for roll out in Northern Ohio in April 2013.

With regard to improving Medicaid managed care plan performance, Mr. McCarthy testified that Ohio Medicaid is looking for changes in contracts that will increase expectations regarding the national performance standards

the plans must meet to receive financial incentive payments. Plans will be required to develop incentives for providers that are tied to improving quality and health outcomes for employees. Due to appeals by the health plans that were not chosen for the program, Ohio Medicaid has delayed enrollment of individuals in the new plans until July 2013.

Director McCarthy also noted that the Office of Health Transformation (OHT) has organized work teams to look at high value policy targets for the budget, a preliminary proposal for which was due to the Office of Budget and Management Oct. 1. Changes to the agency structures that have already been announced include creating a cabinet-level Medicaid department and consolidating the Department of Mental Health and the Department of Alcohol and Drug Addiction Services. Director McCarthy noted that the other work teams are tasked with:

- Further adjustments to nursing facility reimbursement, with a subcommittee report due Dec. 31.
- Creating a unified Medicaid budget and accounting system.
- Coordinating housing programs, workforce programs and programs for children.
- Sharing services across local jurisdictions.
- Integrating U.S. Department of Health and Human Services information capabilities, including eligibility.
- Updating provider regulations to be more person-centered.

Mr. McCarthy also noted that as a result of the United States Supreme Court ruling on the Affordable Care Act (ACA), every state, including Ohio, must decide if it should expand Medicaid eligibility or not; build a state-run Health Benefit Exchange or coordinate with a federal exchange; and further reform the insurance market to promote competition and affordability. As a result of the federal mandate on individuals to purchase health insurance, Ohio Medicaid estimates 320,000 Ohioans who are currently eligible for Medicaid but not enrolled will enroll in January 2014, at an estimated two-year cost of \$700 million state share. Mr. McCarthy noted that the first priority of the state government is to figure out how to absorb these costs within Medicaid and after that time they can consider whether to expand Medicaid eligibility. This will likely occur in the upcoming budget cycle and will include a wide variety of stakeholders. The AMCNO will continue to monitor this discussion.

Ohio Office of Health Transformation Applies for Federal Grant to Change Health Care Payment System

Rather than letting current health care payment systems continue to drain the value out of the care purchased, Governor Kasich directed the Office of Health Transformation (OHT) to engage public and private-sector partners to design and implement systems of payment that create expectations for better care. To that end, recently the OHT applied for a \$3 million State Innovation Model (SIM) design federal grant to support this work and plan an overhaul of the health care payment system with the hope that it will lead to a \$50 million award for actual implementation. The state has always planned to implement payment reform; however, the federal grant would help in making the process happen faster. Also joining this effort with the OHT were the five major health insurance companies: Aetna, Anthem Blue Cross and Blue Shield, Care Source, Medical Mutual and UnitedHealthcare. If the state wins the grant they would expect to have at least \$7.1 million in actual investment in the design phase, while the state and the private insurance payers will contribute \$4.1 million to the effort. OHT is planning on using half of their time and resources over the next year to focus on payment reform. According to OHT, the five health plans will also have to conduct their own internal research and analytics. If the state fails to win the planning grant, it likely will not come up with the \$3 million on its own in the short term. Payment reform ties in with many of the other efforts underway at OHT, as noted in the testimony from Director McCarthy – items such as modernizing Medicaid, the dual eligible project which involves getting multiple payers to collaborate through Medicare and Medicaid; the care coordination for mental health homes and the move to patient-centered medical homes all fit into the OHT payment reform concept.

The State Innovation Model initiative would affect the majority of Ohioans including 1.6 million Medicaid beneficiaries. It would also impact \$82 billion in statewide health expenditures, including \$15 billion on Medicaid, according to the application. About 80% of total health care spending could be addressed through patient-centered medical homes and between 50% and 70% is addressable through episode-based payments. Work is already underway on the payment overhaul but the grant awards will not be announced

LEGISLATIVE AND ADMINISTRATIVE UPDATES

until the end of the year. To view the OHT application go to http://healthtransformation.ohio.gov/LinkClick.aspx?fileticket=v1X1_ceQMaw%3d&tabid=138

Legislation Update

The AMCNO participated in a recent interested party meeting on **HB 143** – a bill which will provide safeguards by requiring the removal of youth athletes from play when signs, symptoms, or behaviors consistent with that of a concussion or head injury are exhibited, and having them cleared by a licensed health care provider in order to return to play. This bill passed in the Ohio House and is currently pending in the Senate Insurance, Commerce and Labor Committee. When the bill passed in the House, amendments had been made to the bill to allow an athlete to return to play if the individual has been assessed and cleared for return to play by a physician or by any other licensed health care provider authorized by the youth sports organization. Medical organizations across the state, including the AMCNO, are concerned with this language

and would like to see the bill amended so that either a referral to a physician occurs prior to return to play or that a licensed health care provider consults or collaborates with a physician before an athlete can return to play following a concussion or head injury. A key focus of the bill is education and awareness and the AMCNO agrees that educating athletic personnel and providers on the nature of a concussion and its symptoms will increase the safety of athletes. The AMCNO supports this bill and will monitor the hearings on this legislation.

Interested party meetings also continue to take place on **HB 417** – a bill which addresses patient continuity of care notification. Currently, the AMCNO has taken this bill under advisement. The legislation, sponsored by Rep. Cheryl Grossman (R-Grove City) requires a health care entity to give notice to patients no later than 10 business days following a physician's termination of employment with the health care entity. The health care entity may provide the terminated physician with a list of the patients' contact

information that the physician has treated in the past two years so the physician can send the notice to their patients. Under current law, Ohio Administrative Code 4731-27-01 requires physicians to notify their patients within 30 days of the last date the physician will see patients when a physician is terminating the physician-patient relationship, leaving, selling or retiring from practice. The required notices shall advise patients of their opportunity to transfer or receive their records and the contact information for obtaining the records. The current law does not address notification requirements when a physician employment relationship is terminated. The state hospital association and hospitals from across the state have requested a number of proposed amendments to the bill, including changing the compliance period from 10 business days to 30 business days and only providing the physician's contact information upon request of the patient. The bill passed the Ohio House in June and is currently pending in the Senate Insurance, Commerce and Labor Committee. Hearings are expected to continue after the election. ■

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AMCNO COMMUNITY OUTREACH

AMCNO Participates in Patient Navigation Collaborative Event

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to be well defined with a clear scope of activity and that the use of a patient navigator can help a patient through the continuum of care in a cost-effective manner. He also noted that it is important to assign navigators to the right area in the health care system and that navigators have the power to bridge the gap between primary and specialty care through coordination and direction. He said that patient navigation has taken hold in the United States pointing out that the American College of Surgeons (ACS) Commission on Cancer has now mandated that in order to pass inspection for ACS hospital centers must have a patient navigation program in place. To date, 1,500 programs have been approved by ACS. In addition, the Affordable Care Act includes a reference to the patient navigation movement indicating that patients who are uninsured should have help in navigating the systems of care.

The panel participants outlined their experiences with the use of patient navigators and also discussed how the use of patient



Dr. Harold Freeman, the founder of the patient navigation concept, outlines the principles of patient navigation.

navigation could impact the healthcare market in Cleveland. Panelists outlined the benefits of patient navigation which included providing education to patients and families on a variety of treatment, nutritional, financial and social issues. Patient navigators also link patient to community resources and support patients as they move through different points of care in the healthcare system.

Going forward, the AMCNO plans to work with the CHA and our other partners in the collaborative to reach out to physicians and their patients to enhance the use of patient navigators in the community in an effort to coordinate patient care and improve health outcomes. We plan to work with the CHA to provide education outreach and other resources necessary to assist in identifying and encouraging physicians to participate in the project in an effort to achieve several outcome goals including reducing no-show rates, appropriately routing emergency department patients, reducing preventable admissions and decreasing lengths of stay, increasing patient compliance rates and outcomes, improving patient and employee satisfaction, decreasing provider workload, and increasing patient access to community support. We believe that through the AMCNO physician leadership we can help the collaborative partners coordinate the necessary education so physicians are working in tandem with hospitals on this process. ■

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Cuyahoga County Health Alliance Tobacco-Free Workshop

Recently, the AMCNO was pleased to host the Cuyahoga County Health Alliance Tobacco-Free Workshop at the AMCNO headquarters. The workshop was part of the Alliance initiative to address health improvement through regional collaboration and provided an opportunity for stakeholders to learn more about establishing a tobacco-free policy in the workplace with a focus on health and wellness for their employees. Participants at the workshop included representatives and mayors from various municipalities, institutional partners, and others involved with the Health Alliance.

The AMCNO president, Dr. James Sechler welcomed participants to the workshop noting that part of the AMCNO's mission is to work collaboratively with other stakeholders in the community on health care related issues and that the AMCNO is pleased to be an institutional partner and part of the County Health Alliance. He noted that curtailing the use of tobacco and promoting tobacco-free policies is an important topic for the physician community and for many years the AMCNO has been working with the local and state health departments and other statewide organizations to find the most effective ways to reduce smoking among both youth and adults. Dr. Sechler provided background on

the AMCNO's advocacy efforts noting that physicians and members of the AMCNO continue to look for ways to increase the funding for tobacco prevention and cessation programs – such as an increase in cigarette and other tobacco products taxes.

Presenters at the workshop provided their insight and experiences on setting up and instituted a tobacco-free workplace. The workshop included presenters from University Hospitals, Cleveland Clinic, the county health department and others. The topics covered included statistics on tobacco use in Cuyahoga County, how to plan a 100% tobacco-free campus policy, how to implement a tobacco-



Representatives from hospitals, health systems and health departments attended the tobacco-free workplace session at the AMCNO.

free campus policy, how to assist employees with tobacco cessation issues, and how to provide incentives and enforce a policy at the workplace. The AMCNO has offered to provide physician presenters at future County Health Alliance workshops. Future workshops are being planned and information will be provided to our members. ■



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AMCNO Hosts Medicare Workshop

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to host a Medicare Workshop where CGS LLC representatives Vanessa Williams, Sonja Rack RN and Juan Lumpkin provided updates on Comprehensive Error Rate Testing (CERT), Recovery Audit Contractor (RAC) and Zone Program Integrity Contractor (ZPIC), Evaluation and Management Services, What is Medically Necessary and Reasonable, Documentation Principles and Tips for an Audit.

CERT Review

The CERT was developed by The Centers for Medicare and Medicaid Services (CMS) with the goal of monitoring and improving the quality and accuracy of Medicare claims processing and payment. By measuring two error rates which include the paid claim error rate and provider compliance error rate; it has been shown the #1 error remains documentation. CMS will continue follow-up calls for the CERT program to obtain all necessary medical record documentation for claims reviewed under the CERT program, which will allow CMS to calculate a more accurate Medicare fee for service error rate, while also reducing the amount of improper payments.



CGS LLC representatives (l to r) Vanessa Williams, Sonja Rack, RN and Juan Lumpkin at Medicare 102 Workshop.

RAC Overview

The program mission for the RAC continues to be to detect and correct past improper payments and implement actions that will prevent future improper payments, lowering the CMS error rate and protecting taxpayers and future Medicare beneficiaries. With a three year look back, it is recommended that physicians and their staff be proactive and periodically review the RAC website for a list of approved issues to know what types of services/equipment are currently being audited in Northeast Ohio.

ZPIC

Ms. Williams explained that the Zone Program Integrity Contractor (ZPIC) is part of CMS and is in place to work on Medicare fraud investigation and prevention, Medicare data analysis, and medical review. ZPIC also reviews audit settlement and reimbursement of cost reports as well as conducting specific audits, outreach and education. It was noted that the Ohio ZPIC is Cahaba Government Benefit Administrators®, LLC (Cahaba GBA).

E&M Update

Evaluation and Management Services (E/M) were also reviewed. The audience had an opportunity to ask questions about resources available, documentation principles and common errors such as electronic signatures and what is an acceptable form of signature and how each is used. ■

CGS Names New Part B Medical Director

CGS has named Dr. Earl Berman as the new Part B Medical Director. Dr. Berman, a native of Savannah, GA, attended Benedictine Military School, University of GA, and Medical College of GA. He has been in the practice of general internal medicine for over 20 years in diverse practice environments. He has practiced in large multi-specialty groups/clinics, urban private practice, rural private practice, sports medicine, student health, hospice, nursing homes, and assisted living. His administrative experience includes being a managing partner in an internal medicine group, managing a five county sports medicine practice, hospice medical director, Medicare CMD for Part B GA, RAC CMD for PRGX auditing 14 states for Medicare and other private/government contracts, and now CMO for CGS. Dr. Berman prides himself on being available to discuss issues promptly and professionally. He also promotes the four cornerstones of communication: clear, concise, correct and considerate. The AMCNO plans to meet with Dr. Berman in the near future.

ICD-10 Delay Frees Physicians to Focus on Other Practice Needs

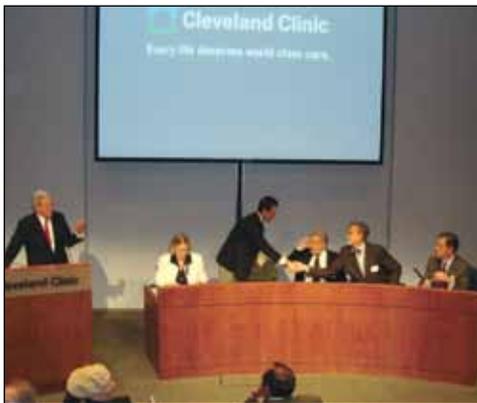
The Dept. of Health and Human Services (HHS) has delayed the compliance deadline for ICD-10 diagnosis code sets that was scheduled for Oct. 1, 2013 so now physicians have more time to focus on other issues while keeping an eye on the eventual switch toward ICD-10. On August 24, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that officially changed the date for complying with ICD-10 medical code data sets to October 1, 2014. The agency decided to pursue the one-year delay versus keeping the original 2013 deadline or bypassing ICD-10 altogether and waiting to adopt ICD-11. The delay allows breathing room for physicians still working toward other regulations such as HIPAA 5010 and the Administrative Simplification of HIPAA provision, as well as meaningful use. However, physicians should not assume that the delay for ICD-10 compliance is indefinite and analysts have suggested that practices that are still looking to implement an EHR system should be sure that the product they choose has both cross-walk capabilities (the ability to map ICD-9 sets to ICD-10 sets) as well as the ability to capture ICD-10 codes natively. As noted in previous articles in the Northern Ohio Physician magazine, it is suggested that physicians and their practice management staff should not focus too much on training and testing until closer to the compliance date. Early training may need to be repeated, either because employees forget what was taught or because of staff changes. But physicians are cautioned not to wait until the last minute since vendors, organizations and other groups providing ICD-10 training will be backlogged in weeks leading up to the compliance deadline.

AMCNO Hosts Health System Reform Event

With this summer's Supreme Court decision to uphold the Affordable Care Act (ACA) paired with the upcoming election, many Ohioans, especially physicians, have been asking what is next for health system reform in Ohio. To address this question, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the Ohio State Medical Association (OSMA) recently hosted an event entitled, **"From the ACA to ACOs and Beyond: What's Next for Health System Reform in Ohio?"**

The event featured a panel of legislators discussing Ohio's next steps on ACA implementation as well as a roundtable of physician leaders addressing how health system reform could impact patient care.

The legislative panel included Rep. Barbara Sears (R-46) who is currently serving as the Assistant Majority Floor Leader of the Ohio House of Representatives. Also on the panel was Armond Budish (D-8), who is the Minority Leader of the Ohio House of Representatives. Rep. Sears noted that the ACA is requiring massive changes in Medicaid reimbursement and eligibility, information technology implementation and establishing health exchanges and all of this is to occur in 18 short months. She noted that all of these issues have to be reviewed very carefully with an eye as to how it could impact the Ohio budget. Rep. Sears noted that there are concerns that for the first three years these changes would be covered 100% but after three years there will be a question regarding sustainability. Rep. Budish noted that there are



Mr. Oliver Henkel, Cleveland Clinic Chief Government Relations Officer, introduces the physician panelists. (Panelists left to right) Dr. Mary Wall, Dr. John Bastulli, Dr. David Longworth, Dr. Alfred Connors and Dr. Michael Anderson



Panel participants spend a moment with the president of the AMCNO and the OSMA. Left to right: Dr. Michael Anderson, Dr. James Sechler, AMCNO president, Oliver Henkel, Dr. Mary Wall, Dr. Deepak Kumar, OSMA president, and Dr. John Bastulli.

many questions under review such as who should set up and run a statewide health exchange, noting that the ACA requires states to set up healthcare exchanges, but allows them to choose not to, in which case the federal government will do it for them. He noted there are two pieces of legislation in Ohio to set up a health exchange and these are under review. On the topic of whether or not Medicaid should expand in Ohio, Rep. Budish commented that the Ohio Hospital Association supports an expansion of eligibility and he believes it will bring additional funds into Ohio. He also noted that expansion of Medicaid would allow the state to bring families who would otherwise not be covered into the system.

The physician panelists included Dr. Mary Wall from central Ohio representing the OSMA, Dr. John Bastulli representing the AMCNO, Dr. Alfred Connors representing MetroHealth, Dr. Michael Anderson representing University Hospitals, and Dr. David Longworth representing the Cleveland Clinic. Dr. Wall discussed her experience practicing in North Central Ohio where there are still a large number of solo practitioners. Dr. Bastulli outlined the AMCNO position on health care reform and noted that the AMCNO wants to assure that the expansion of Medicaid or establishing a health exchange does not adversely impact the patient/physician relationship. Dr. Connors outlined how MetroHealth has responded to the ACA by establishing patient centered medical home models in all of their primary care settings as well as implementing a robust electronic



Rep. Barbara Sears spends a moment with Rep. Armond Budish following the session.

medical record model. Dr. Anderson expressed concern about ongoing graduate medical education (GME) funding and he noted that if cuts are made to GME it could impact patient care. Dr. Longworth noted that the current rate of cost escalation in healthcare in this country is unsustainable and that physicians and healthcare systems will have to deliver on the value proposition of higher quality and lower costs. Members of the panel also agreed that in the future it may be difficult for a new physician starting out in practice to become an independent practitioner due to all of the rules and regulations being implemented as part of the ACA.

The AMCNO would like to thank the Cleveland Clinic for hosting the event and we would also like to thank the OSMA for co-sponsoring the event with the AMCNO. ■

AMCNO MEMBERSHIP OUTREACH

Why I Joined AMCNO

By Dr. Laura David



About 15 years ago, I began to realize that as a single practitioner, my ability to promote the things I cared about most and my individual influence on the forces around me were dwindling. My concern for patient care and autonomy in the physician/patient relationship and my ability to make my voice heard when business and political actions seemed to dominate legislative decisions had become trivialized. Only by joining with other physicians could I cope with the world of ever expanding hospital systems and powerful politicians.

I remain a member in AMCNO because I continue to find strength, camaraderie, leadership and mentoring from my other colleagues. The AMCNO remains vital and versatile: we are involved in community action and education, charitable care, scholarship fundraising, legislative activity and interaction with hospital administrators and legal experts. We are focused, efficient and energetic in the pursuit of the best practice of medicine and the best professional atmosphere for our members and our community. And I value the continued opportunities to interact with colleagues from

all over the region and to participate in activities in many arenas that augment the day to day activity of my own private office.

Anyone who has not given the AMCNO a try should consider membership! Alone, no matter how we are motivated or how much time we have to spend, each of us has only limited resources. But as a large and cohesive group, we can assert much influence, share many experiences and enjoy the satisfaction of a thriving profession and a thriving professional relationship with our colleagues. ■

*To all Members of the
Academy of Medicine of
Cleveland & Northern Ohio
(AMCNO)*

*Your AMCNO Board of
Directors and Staff*

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&
HEALTHY
HOLIDAY
SEASON**

Why do more of Northeast Ohio's physicians recommend Hospice of the Western Reserve?

Dr. Wellman knows.

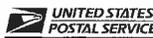


Chief Medical Officer, Dr. Charles Wellman oversees Hospice of the Western Reserve's teams who make more home visits than any other hospice program in Northeast Ohio. Dr. Wellman and his staff work to ensure patients and families get the care and support they need. We're available 24/7 to help. Contact us today for a free resource guide for you, your patients and their families.



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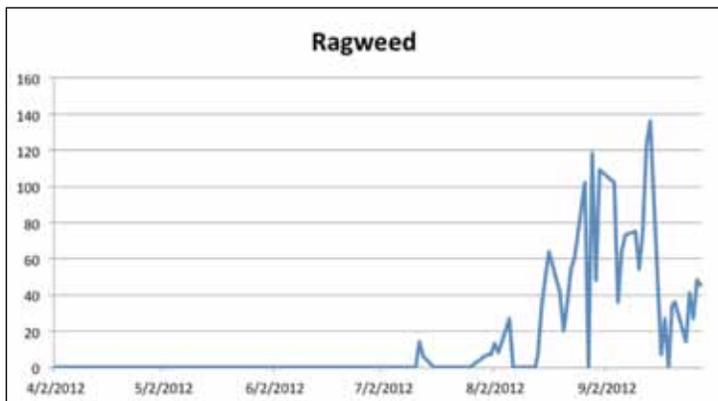
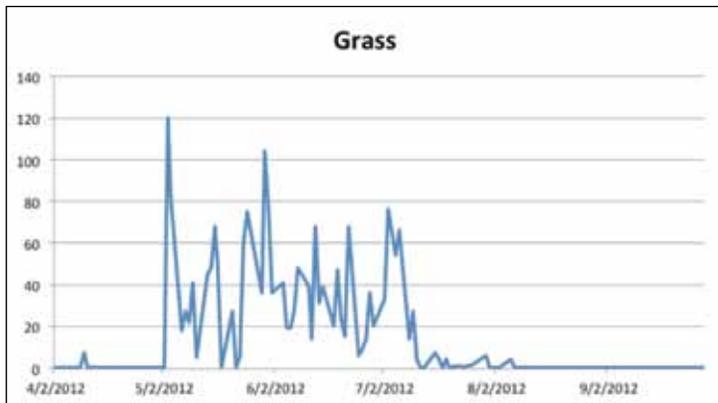
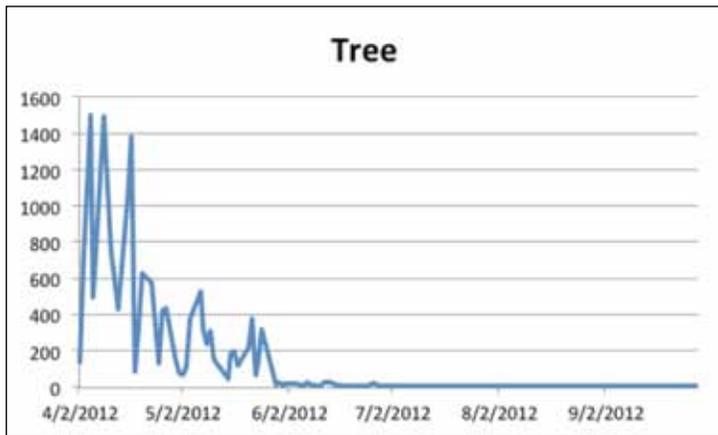
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AMCNO Pollen Line – 2012 Recap

By Jonathan Horbal, D.O., M.S.; Devi Jhaveri, D.O.; Julie Sterbank, D.O.; Theodore Sher, M.D.; Haig Tcheurekdjian, M.D., and Robert Hostoffer, D.O.

Over the 2012 pollen season the AMCNO continued to use a Rotorod Aeorallergen device, to track local pollen levels. With the help of the AMCNO's pollen line and website, a report was made each morning throughout the pollen season. This vital information is provided during the pollen season to allow allergists and other physicians to communicate to their patients when to start medications for alleviation of symptoms from allergic rhinitis, allergic conjunctivitis and asthma.



Pollen season in the Cleveland area begins with the observation of tree pollens and usually starts in April. This year the pollen season started earlier than usual when pollen values started low and then spiked to high levels over the first week of April. As the month progressed a downtrend-spiking pattern was seen and continued in the same pattern over May. The tree pollen season was over by the first week in June.

Grass season began with a sharp peak in May. The overall course of the season was prolonged compared to the tree season, which was two months in duration. Grass pollens could be seen in high concentrations over three to four months and was persistent throughout the season. As displayed by the graphical presentation there were peaks in the pollen counts at the beginning of each month in the season. This long season could have been attributed to the long-hot summer we experienced in Northern Ohio. During each month there was a slight downtrend but levels still remained in the high range over the season. Grass pollen counts finally came into the low value range in the second week of July.

Ragweed season historically has started around June 15th in the Cleveland area, however, this year there was a moderate peak three days prior to the normal starting date and it trended upward and peaked in September. There was a period where the values were found to be low at the end of August, which correlated to a period of constant rainy weather. Ragweed values showed a slight upward movement as the season came to a close. These values will remain at low values and end when the Cleveland area experiences its first frost.

The mold component of the pollen count was persistent throughout the year, but did increase in the fall months, when leaves fell from the trees and created a collection/growing point for mold spores. There were two moderate peaks seen in August that were not consistent with the shedding of leaves from the trees.

Pollen counting will start again next year on April 1, 2013 and the pollen count can be obtained by calling the AMCNO pollen line at (216) 520-1050 or at www.amcno.org. Patients and physicians can also follow the AMCNO on Twitter to obtain daily pollen counts. AMCNO looks forward to beginning this count again to provide a barometer to physicians and patients in the greater Cleveland area in order to make pollen season as tolerable as possible.

Editor's Note: The AMCNO gratefully acknowledges the work of Allergy Immunology Associates and expresses our appreciation to the group for providing the AMCNO pollen counts during allergy season. The AMCNO pollen count will return on April 1, 2013. ■

Identification and Management of Lead Exposure in Pregnant and Lactating Women

By Scott Frank, M.D., M.S.

The best part of practicing obstetrics as a family physician is that you get to keep the babies. While I shared the delivery suite with obstetricians and midwives, they handed care of the infant over to the pediatrician or family physician. We each had the privilege of helping to guide a woman and her family through the normative crisis of pregnancy, labor and delivery, and postpartum care. But for 20 years, as I attended labor and delivery in Cleveland, I got to keep the babies.

The privilege and trust developed through this obstetrical care extended into the joy of watching and guiding these beautiful babies through infancy and toddlerhood, tweens and teens, and into adulthood. Being there to offer anticipatory guidance through breastfeeding and sleepless nights, through terrible two's and turbulent teens, through social and intellectual youth development counts among the most challenging and most rewarding components of my professional life. I still care for a large cohort of the grown children I delivered.

But the gratification experienced through the development of these relationships was always diminished to some degree by the reality of disparities in health I observed based on residence of birth. Babies born in the same city and the same hospitals, supported by the same nurses and delivered by the same doctors entered life in very different states of health with very different opportunities to mature and to express their greatness. Clearly, perinatal and neonatal health is influenced by many diverse factors, from access to quality medical care to the chronic stress of poverty, unemployment, to the social support received from families and friends.

While the practicing physician may feel unable to influence systemic inequities, there is something we can do. Pediatricians and family physicians have long recognized the profound impact of lead exposure on young brain, even at levels once considered to be "normal." As a result of recently issued guidelines the Centers for Disease Control and Prevention (CDC), all healthcare providers caring for pregnant or lactating women have an opportunity to eliminate the insidious, life-altering penalty suffered by infants resulting from intrapartum and neonatal lead exposure.

Based on developing research regarding screening and management of maternal lead exposure, there is critical new information regarding what we can do to protect infants from impaired fetal growth and neuro-development resulting from these imperiling, unrecognized environmental exposures. We know that lead readily crosses the placenta and into breast milk. We know that there is no known "safe" blood lead concentration.

We know that elevated blood lead levels (BLL) in children are associated with significant decreases in IQ and with increases in violent and antisocial behaviors as teens and adults.

The good news is that we can do something about it. The first step is screening. CDC guidelines recommend screening high risk women for elevated BLL. When considering risk factors for screening, think **ROVER**:

- Residence in a home built before 1978 (especially with deteriorating paint or recent renovation); or in a home near a smelting or battery recycling facility
- Occupational exposure (personal or through another household member)
- Vitamin Deficiency, including calcium, iron, zinc, vitamin C or vitamin D
- Elevated lead level (personal history or in another household member)
- Recent immigration or cultural practices that include some traditional remedies (especially among Indian, Middle Eastern, West Asian, and Hispanic cultures)

Additionally, more unusual lead risks include pica behavior, use of lead glazed pottery for cooking and eating, and use of imported eye cosmetics (especially from Middle East, India, Pakistan, and Africa).

If screening indicates BLL $\geq 5\mu\text{g/dL}$, intervention is indicated. Management of women with elevated BLL revolves around decreasing lead exposure, supplementation (calcium, vitamin D and iron), and avoiding breastfeeding if maternal BLL $\geq 40\mu\text{g/dL}$. Priority one is avoiding further lead exposure through addressing the risk factors above and frequent hand-washing. Priority two involves recognizing the role of calcium in management of elevated maternal BLL. Ninety percent of the body's lead resides in bone. Increased mobilization of calcium from bone during pregnancy and lactation may release stored lead into the maternal circulation. In addition to its role in slowing bone calcium mobilization, adequate calcium intake is believed to reduce GI lead absorption. Two large trials have shown substantial reductions in BLL among pregnant or lactating women receiving calcium supplementation. Finally, with maternal BLL $\geq 40\mu\text{g/dL}$, continue

pumping and discard the breast milk until the BLL falls below $\geq 40\mu\text{g/dL}$.

I stopped delivering babies in 2004, not because I was burned out by the long hours or because of increasing malpractice premiums, but as a result of my developing identity as a family physician *and* public health practitioner. I am chastened to acknowledge that not once during my 20 years of providing prenatal care did I screen for elevated maternal BLL. It was not recognized as necessary or as standard of care at the time. I am equally affirmed in my dedication to the integration of public health and medicine. It is in fact public health research that offers recommendations for screening and elevated BLL management. It is in fact in the medical settings where these recommendations can be realized.

Now, as Director of Health for the City of Shaker Heights and Director of the Master of Public Health Program at the Case Western Reserve University School of Medicine, I have an opportunity to guide friends and colleagues in both fields to the bridges, backroads and barely beaten pathways that connect public health and medicine. Bridges, backroads and pathways that lead to healthier beautiful babies, better opportunities for a future unencumbered by lead exposure, and fewer disparities in health based on unintended environmental exposures in early life.

As physicians, we have limited opportunities to mitigate the trauma of chronic stress from poverty and unemployment, but what we can do is screen for elevated BLL in high risk women and manage elevated levels effectively when detected. Fulfillment grows from doing best what people need most. So think prevention. Think **ROVER**. At risk pregnant women *need* BLL screening.

For additional information or resources, contact your local health department. Full CDC guidelines are available at <http://www.cdc.gov/nceh/lead/publications/leadandpregnancy2010.pdf>

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 Abby Bell or Joyce McIntosh at the AMCNO offices at (216) 520-1000. ■

A Physician's Guide to Understanding the Litigation Process: Answers to Frequently Asked Questions

By Richard Rymond, Esq. and David Valent, Esq. of Reminger Co., L.P.A.

This guide is intended to help answer questions that commonly arise within the medical malpractice litigation process. While we cannot eliminate all the frustration and unpleasantness of being involved in a lawsuit, we hope to reduce some of your potential anxiety by answering several frequently asked questions.

Being named in a lawsuit is not a reflection of your ability or competence. Over the course of a successful career, it is likely that you will be sued for malpractice on one or more occasions, even if the care at issue is entirely appropriate.

I have been sued. What do I do?

In most cases, you will learn of the lawsuit upon receipt of legal documents issued by the Court. These documents will generally include a Complaint and Summons, indicating that you have been named as a defendant in a civil lawsuit.

The Complaint itself is often vague, but in some instances it may include specific allegations regarding your care and treatment of the patient (plaintiff). In Ohio, the Plaintiff is required to submit an Affidavit of Merit along with the Complaint, or, in the alternative, a request for additional time in which to submit an Affidavit of Merit. The Affidavit is a signed statement from a physician indicating that, in his/her opinion, your care fell below accepted standards and caused injury to the patient.

Your response to Summons and Complaint must be made in a timely manner, or your defense may be seriously jeopardized. To ensure a timely response, upon your receipt of a Complaint, you should immediately contact your insurance carrier and/or attorney. You should not respond to the Complaint on your own. Under no circumstances should you contact the patient or the attorney who is representing the patient.

Typically, your insurance carrier will assign an attorney to defend you in the case. In some instances, you will have an opportunity to participate in the selection of your attorney.

What Should I do with My Records for the Patient/Plaintiff?

Your complete original chart should be kept in a safe and secure location. In the event that any portions of your chart are missing, the patient's attorney is likely going to attempt to argue that the "missing records" would have somehow been helpful to the plaintiff's case and/or that you intentionally misplaced the

records because they were harmful to your case. Of course, in most instances, this could not be further from the truth. Nevertheless, to reduce the risk of any such argument by the patient's attorney, please take all measures possible to secure the complete chart for production to your attorney. Do not make any additions, changes, corrections, or modifications to the original chart. Adding information to the medical record, after the fact, can give the wrong impression to the judge and/or jury. While poor documentation is not desirable, it is easier to defend poor documentation than it is to defend altered records. Also, in Ohio, a finding that records have been altered, may expose you to "punitive damages" which are typically not covered by professional liability insurance.

I Have Informed My Insurance Carrier and Attorney of the Lawsuit. What Happens Next?

It is likely that your attorney will contact you to set an initial meeting to discuss the case with you. This will be an opportunity for you to explain your recollection of events and/or your review of the medical record. Your attorney will also further explain to you the remainder of the litigation process.

The next step will be the exchange of "discovery." Generally, discovery begins with the exchange of written questions and requests for pertinent documents between all parties to the lawsuit.

Often, after paper documents are exchanged, the next step in discovery involves the depositions of the named parties, and the important fact witnesses. A deposition is a formal question and answer session, under oath, conducted by counsel, and recorded by a stenographer. Your attorney will meet with you prior to your deposition to discuss this process in further detail.

During the discovery phase of the case, your attorney will also likely retain the services of a physician in your specialty to assist with evaluating your case, and to help prepare your defense. If that physician believes that you met the accepted standard of care in your

treatment of the patient, the physician will then likely serve as an expert witness on your behalf at trial. Prior to trial, the opposing attorney will have the opportunity to take the deposition of your expert(s) in order to fully explore their opinions and credibility. Similarly, your attorney will have the opportunity to take the deposition of the patient's expert(s).

Ultimately, an assessment will be made as to whether the case should be resolved or whether the case should proceed to trial. If the case goes to trial, it will likely be heard by a jury. In Ohio, most juries consist of eight (8) people. Six (6) of the eight (8) jurors must agree on a verdict.

How Much Time Will I Need Away from My Practice?

Is important to remember that this is your case, and your active participation is essential to a successful outcome. The amount of preparation you put into the case can make a significant difference in the result. Your attorney's work on your behalf cannot serve as a substitute for the work that you need to do in preparing for deposition, understanding the issues, and preparing for trial. To that end, you will need to meet with your attorney several times throughout the pendency of the lawsuit.

The trial itself will also require your attendance and participation. Most medical malpractice trials last between one to two weeks, and sometimes longer.

What is My Attorney's Responsibility to Me in the "Tripartite Relationship"?

The tripartite relationship refers to the relationship between you, your insurance company and the lawyer who is hired by your insurance company to represent you. Pursuant to the tripartite relationship, you have a duty to cooperate with your insurance company. The insurance company has a duty to pay for your defense and indemnify you pursuant to the terms of your insurance contract. The attorney is hired to represent your interests not the insurance carrier's interests. In those rare instances where there is some sort of conflict between you and the insurance carrier, the attorney retained by the insurance company will not become actively involved in that conflict, but rather, will advise you to retain separate counsel to address issues which may arise as a result of that conflict.

What is the "National Practitioner Data Bank"?

When a malpractice claim is settled with a payment by a third-party (i.e., insurance carrier) on behalf of a physician, the payment must be reported to the National Practitioner Data Bank (NPDB). Failure to make a report may expose those involved to substantial fines.

By design, the information reported to the NPDB is not available to the public. However, the information is available to State licensing authorities and health care entities, to be reviewed for purposes of making hiring decisions and/or granting privileges.

What does "Consent to Settle" Mean?

Your professional liability insurance policy may contain language that requires your insurance carrier to have your "consent to settle." This means that your insurance carrier cannot negotiate a settlement of a covered claim without your permission.

Can I Sue the Plaintiff/Plaintiff's Attorney or Plaintiff's Expert?

After obtaining a favorable result, physicians often inquire whether they have the right to sue for the time, stress and expense involved in defending a meritless lawsuit. Unfortunately, it is very difficult to successfully countersue a plaintiff (the person who is initiating the lawsuit) and/or their attorney and/or expert.

As long as the plaintiff can show a good faith reason for thinking he/she had a claim against you, it is unlikely that you would prevail in an attempt to countersue him/her. The same is true of the plaintiff's attorney and/or expert.

Should I Expect the Litigation Process to be Stressful?

Many health care providers experience a great deal of stress associated with the litigation process, even if the outcome is favorable to the physician. You should understand that very few professional malpractice cases have a significant impact on a physician's personal finances, family, or ability to continue practicing.

In the event that you find yourself dwelling on your lawsuit, and if it interferes with your practice or other activities, you should speak to your insurance carrier and/or attorney. In some instances, it is appropriate to seek counseling to help deal with the stress associated with litigation.

In closing, nothing in this article is intended to be construed as legal advice. For legal advice and/or for answers to your specific questions, please do not hesitate to contact your attorney or the authors of this article. ■

Call for 2013 AMCNO Honorees

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

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

• Your Name: _____

• Your Nominee: _____

• Nominated for the following award: _____

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

Are you Interested in running for the AMCNO Board of Directors in 2013?

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

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

Name and Contact information: _____

AMCNO Participates in Ohio Health Literacy Conference

The third session of the Ohio Healthy Literacy Conference Series – Health Literacy: What Is It, What To Do About It, Why Is It Important, was recently held at St. Vincent Charity Medical Center. Karen Komondor, Director of Education, St. Vincent's Charity Hospital, Richard Peterson, CEO, Project Learn and Jodi Turosky, Clinical Manager, Pharmacy, St. Vincent Charity Medical Center were the speakers.

Why is it important? It was noted that up to 80% of medical information provided to patients by healthcare providers is forgotten almost immediately, and almost half of what is remembered is incorrect. Approximately 20% of American adults read at or below 5th grade level and most health materials are written at the 10th grade level or higher. This becomes a problem when trying to fill out consent forms, understanding educational brochures regarding disease and treatment options, and even understanding how to take medications.

What to do about it? Some strategies to improve health literacy are: explain things using plain language with two syllables or less; use plain non-medical language like pain-killer instead of analgesic; focus on key messages, and limit the messages to 1-3 per visit. Another helpful tool is to use teach back or show me techniques and ask the patient to demonstrate their level of understanding.

Formatting and readability are another way to increase literacy. Some examples given were the use of more white space, short



Ohio Literacy Conference presenters pose for the camera. Left to right: Jodi Turosky, Clinical Manager, Pharmacy, St. Vincent Charity Medical Center, Karen Komondor, Director of Education, St. Vincent Charity Medical Center and Richard Peterson, CEO, Project Learn

paragraphs, aiming for a 6th grade reading level and eliminating graphs and charts. The final session of this series will be held at the end of October. ■



December 6, 2012 // 12:30 to 5:00 pm

Embassy Suites in Independence

5800 Rockside Woods Boulevard Independence, OH 44131

Medical Malpractice Claims – The Impact of Being Sued

Sponsored by **Roetzel & Andress** and the **Academy of Medicine of Cleveland and Northern Ohio (AMCNO)**, this half-day seminar will address various risk management and medical legal issues, including the lawsuit and trial process, the nuts and bolts of medical malpractice trial preparation, False Claims Act (FCA), and the emotional and psychological impact of being sued on a health care provider.

RSVP by **November 30** by emailing **Kristen Warnke** at kwarnke@ralaw.com or contact her via phone at **330.762.7725**.

ROETZEL & ANDRESS



State Medical Board of Ohio Provides Telemedicine Interpretative Guidelines

The State Medical Board of Ohio has received numerous inquiries concerning the requirement to “personally physically examine and diagnose a patient” prior to prescribing, as set forth in Ohio Administrative Code Rule 4731-11-09. The inquiries raise questions regarding the ability to use the Internet or other forms of telecommunication to complete the physical examination of a patient that is the basis for a diagnosis and follow through on a plan of treatment for the individual patient.

In order to respond to these inquiries, the SMBO has prepared a document to address these inquiries and provide guidance to physicians and other authorized prescribers (such as Advanced Practice Nurses or Physician Assistants). The interpretation of Rule 4731-11-09 and the requirement to personally physically examine and diagnose a patient applies solely to cases that involve prescribing or personally furnishing non-controlled substances. This statement does not address prescribing for controlled substances¹ or the provision of tele-psychiatry as provided in Rule 4731-11-09.

Ohio Administrative Code Rule 4731-11-09 generally requires a physician or other authorized prescriber to personally physically examine and diagnose a person prior to initially prescribing, dispensing, otherwise providing or causing to be provided any controlled substance or non-controlled substance. However, exceptions to Rule 4731-11-09 provide for situations where the personal physical examination and diagnoses standards are otherwise likely to have been met including: institutional settings, on call situations, cross coverage situations, situations involving new patients, protocol situations, situations involving advanced practice nurses practicing in accordance with standard care arrangements, and hospice settings.²

Rule 4731-11-09 promotes the importance of the physician-patient relationship and the need to conform to minimal standards of care, especially in cases where prescribing of dangerous drugs is deemed necessary. The rule was initially adopted in response to a growing trend of physicians issuing prescriptions for dangerous drugs to persons without the benefit of reliable diagnostic information. These physicians prescribed using abbreviated medical histories, usually obtained via the Internet or in a few cases with a phone call to the patient. The physicians failed to conduct physical examinations and the way they practiced did not allow for positive identification of patients. At the time of the rule's adoption telemedicine consisted primarily of telephone consults between physicians and electronic

transmission of radiographic images and reports. Today the Board recognizes that with advances in medical technology it may be possible for the “personal” and “physical” examination required by Rule 4731-11-09 to occur when the provider and patient are located in remote locations.

SMBO Interpretative Guideline

When personally physically examining a patient who is located in a remote location, the physician or authorized prescriber should obtain a reliable medical history and perform a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions and/or contraindications to the treatment recommended/provided and conform to minimal standards of care. Prior to initially prescribing non-controlled substances the physician or authorized prescriber should: (a) establish or have previously established a valid provider patient relationship; (b) have appropriate diagnostic medical equipment capable of transmitting in real-time the patient's vital signs and other physical data; (c) have appropriate diagnostic medical equipment capable of transmitting in real-time images of the patients symptoms and that also has the ability to be adjusted for better image quality and definition; (d) have sufficient dialogue

with the patient regarding treatment options and the risks and benefits of treatment(s); (e) as appropriate, follow up with the patient to assess the therapeutic outcome; (f) maintain a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to his or her other health care professionals; and (g) include the electronic prescription information as part of the patient medical record.

The standards outlined in this document are based in part on those established by the American Medical Association guidance document H-120.949 “Guidance for Physicians on Internet Prescribing.” *This statement should not be construed as new law; rather it is an attempt to clarify existing regulations. Such clarification is intended for the benefit of practitioners and the public as a way to promote better understanding of the laws governing the practice of medicine. This interpretative guideline was adopted by the SMBO in September, 2012.* For additional information contact the SMBO. ■

1. Section 309 of the Controlled Substances Act (21 U.S.C. 829) sets forth certain requirements when prescribing controlled substances which require an in-person medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals.
2. Rule 4731-11-09 (B), Ohio Administrative Code provides an additional exception for a physician who is prescribing non-controlled substances to a patient in consultation with another physician who has an ongoing professional relationship with the patient, and has agreed to supervise the patient's use of the drug or drugs to be provided.

AMCNO Highlighted on Agency for Healthcare Research and Quality (AHRQ) Partners in Action Website

The AMCNO board of directors agreed to partner with AHRQ to share AHRQ's patient-centered outcomes research, also known as comparative effectiveness research, with our members and their patients. AHRQ is a Federal agency of the U.S. Department of Health and Human Services charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. The Academy of Medicine of Cleveland and Northern Ohio is an ideal partner to help disseminate this research, which is designed to inform health care decisions by providing unbiased comparisons of drugs, medical devices, tests, surgeries, or delivery methods for various health conditions. As a result of the marketing done by the AMCNO on our website and in our publications about the partnership, AHRQ has decided to highlight the AMCNO and publish a brief article about our partnership in the “Partners in Action” section of their website. To view the AHRQ AMCNO Partners in Action link go to our website at www.amcno.org and click on Education and Events.

Annual AMCNO Mini-Internship Program Provides Insight into the Practice of Medicine

The Academy of Medicine of Cleveland & Northern Ohio was pleased to facilitate the Annual Mini-Internship Program October 15 through 17, with both physician and intern participants relating the many benefits of the two-day shadowing experience. Now in its' 28th consecutive year, the AMCNO is proud to have one of the longest running mini-internship programs in the country.

From hematology, pediatric neurology to gastroenterology, plastic surgery, internal medicine, cardiology, family medicine, rheumatology, ophthalmology, pediatrics and, orthopedic shoulder and knee surgeries, interns experienced a "Day in the Life" of local physicians, an unparalleled look at the practice of medicine in today's healthcare arena.

The response from both community leaders and member physicians participating in the 2012 program was impressive. The program kicked off with a brief orientation, where interns and their respective physician(s) met, last minute information was exchanged, and program goals were shared by Chairman William Seitz, Jr. M.D.

A debriefing dinner was held at the end of the event where interns and physicians exchanged comments and perspectives about their experiences. The interns saw the experience to be profoundly rewarding and eye-opening, dramatically changing their views about what it takes to practice medicine. Ms. Rothenberg-James commented that her mini-internship opportunity afforded her a life changing experience and stated that she would do this every day if she could.

Ms. Werren expressed her gratitude to the doctors who participated and to the AMCNO for the invitation to participate in the program saying that it was a fantastic experience. By the end of the first day she said she was tired, but she couldn't wait to get up and do it again the next day noting that seeing it from the inside gave her a newfound respect for the profession.

Ms. Diane Suchetka admitted that as a reporter she was somewhat skeptical at first but would do another internship if she could.

She found the experience to be amazing and felt that the opportunity will make her a better person on the job, a better advocate for her family and a better patient.

Mr. Campanella stated that his mini-internship experience will stand out in his 30 years in the healthcare industry and he commented on his surgical experience noting the confidence of the staff and how the entire team worked together. He also noted that politicians and business people are setting rules for physicians and that the medical profession should be sure to take a more proactive role when possible. Dr. Seitz pointed out to the group that the AMCNO did have an active legislative committee that welcomes physician participation.

Mr. LaGuardia stated that he was impressed with the courtesy, efficiency and true patient caring he observed during his internship. He saw firsthand that the medical profession is a balance of art and science and found his experience to be very rewarding. He agreed that the teamwork during surgery and the patient centered care were amazing.

Mr. Strang also commented about his remarkable surgery experience and noted that

he also gained insight into the differences between law and medicine.

Dr. William Seitz Jr. reminded the interns of the common thread running through all of their experiences, giving them the ability to reflect on what they've experienced, and asked that the interns share those experiences with others.

Physician participants were asked to provide insight on what they felt the interns gained from their experience. Overall the physician participants agreed that the interns gained a perspective about physician/patient interactions, an appreciation for the effort physicians make to communicate with their patients and express empathy, a clearer understanding of the challenges of time and resources physicians face each day as well as a sense of how busy physicians are and how much time is spent on paperwork and administrative issues. Overall, all of the physician participants enjoyed the experience and would participate in the program next year.

The AMCNO expresses its sincerest appreciation to both the doctors and community members who committed their time and effort to make this very special program a true success again this year. ■

2012 Physician Participants

William Seitz Jr., M.D., Chairman
Tom Abelson, M.D.
Dale Cowan, M.D.
Robert DeBernardo, M.D.
Debabrata Ghosh, M.D.
Reuben Gobezie, M.D.
Gerard Isenberg, M.D.
Fred Jorgensen, M.D.
Bram Kaufman, M.D.
Patricia Kellner, M.D.
Lawrence Kent, M.D.
Louis Keppler, M.D.
Umesh Khot, M.D.
Matthew Levy, M.D.
Christopher McHenry, M.D.
Prateek Mendiratta, M.D.
James Sechler, M.D.
Howard Smith, M.D.
Robert M Stern, M.D.
Anna Winfield, M.D.

2012 Program Interns

Thomas Campanella, Baldwin Wallace University, Director of Healthcare MBA
Joseph Laguardia, Kaiser Permanente, Vice President of Marketing, Sales and Business Development
Kathy Rothenberg-James, Cleveland Dept. of Public Health, Health Center Director / HIPAA Privacy Contact Officer
Carter Strang, Tucker Ellis and President, Cleveland Metropolitan Bar Association
Diane Suchetka, The Plain Dealer, Healthcare Reporter
Bobbijo Werren, Comp Management, Inc., Account Executive

AMCNO MINI-INTERNSHIP



The 2012 AMCNO Mini-Internship participants pose for the camera. Left to right: Ms. Diane Suchetka, Mr. Tom Campanella, Ms. Bobbijo Werren, Ms. Kathy Rothenberg-James, Mr. Carter Strang and Mr. Joseph LaGuardia.



Mr. Carter Strang with his physicians and diploma. Left to right: Dr. Prateek Mendiratta, Dr. Bram Kaufman, Mr. Strang and Dr. Dale Cowan



Ms. Bobbijo Werren with her physicians. Left to right: Dr. Bram Kaufman, Dr. Matthew Levy, Ms. Werren and Dr. Anna Winfield



Top row left to right: Dr. Robert Stern, Dr. Dale Cowan, Dr. James Sechler, Dr. Matthew Levy, Dr. Umesh Khot, Dr. Debabrata Ghosh, Dr. Prateek Mendiratta, Dr. Fred Jorgensen, Dr. Anna Winfield, Dr. Lawrence Kent, Dr. Gerard Isenberg, Dr. Tom Abelson, and Dr. William Seitz, Jr. Seated from left to right: Ms. Diane Suchetka, Ms. Bobbijo Werren, Mr. Carter Strang, Mr. Tom Campanella, Ms. Kathy Rothenberg-James and Mr. Joseph LaGuardia.



Ms. Diane Suchetka receives her mini-internship diploma from her physicians. Dr. Matthew Levy and Dr. James Sechler (left) and Dr. Debabrata Ghosh (right)



Mr. LaGuardia strikes a pose with his physician participants. Left to right: Dr. Robert Stern, Dr. Tom Abelson, Mr. LaGuardia and Dr. William Seitz, Jr.



Mr. Tom Campanella receives his mini-internship diploma from AMCNO President Dr. James Sechler.



Ms. Bobbijo Werren discusses her mini-internship experience with Dr. Bram Kaufman.



Dr. Fred Jorgensen (left) and Dr. Lawrence Kent pose with their intern, Ms. Kathy Rothenberg-James.



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