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AMC/NOMA President Presents at Medical Hall of Fame

The AMC/NOMA congratulates **Dr. John D. Hines,** a hematologist/oncologist at The Cleveland Clinic in Strongsville and Parma, who was recently inducted into the 2004 *Cleveland Magazine* Medical Hall of Fame, held Wednesday, Nov. 3 at Windows on the River. Dr. Hines, a physician specially trained in chemotherapy treatments that attempt to kill cancer cells by injecting chemicals into the bloodstream, was one of three doctors this year to earn the distinction. The two other physicians inducted were from University Hospitals while a Ph.D. from Lerner Research Institute and a Case faculty member were recognized for Excellence in Research.

The AMC/NOMA President **Dr. William H. Seitz, Jr., M.D.,** had the honor of presenting the 2004 posthumous award to Charter Member inductee **Dr. Frank Nulsen, M.D.,** former chairman of the Case Western Reserve University School of Medicine's Neurosurgical Department and past AMC/NOMA member who died in 1994. Dr. Nulsen was known as the innovator for the utilization of the shunt in hydrocephalus, a force in the treatment of gun-related nerve injuries, a caring doctor, a formidable academic and according to those who knew him, a very clever man.

Case Western Reserve University School of Medicine, Reminger & Reminger Attorney at Law and Butler Wick sponsored the eighth annual program that is presented by *Cleveland Magazine* to honor the city's distinguished medical community. Proceeds from the event support scholarships for Case medical students. ■

The AMC/NOMA President, ***Dr. William H. Seitz, Jr., M.D.,*** *presents the 2004 posthumous award to Charter Member inductee* ***Dr. Frank Nulsen,*** *past AMC/NOMA member who passed away in 1994.*

Touting Tort Reform to Business Leaders

Dr. John A. Bastulli, AMC/NOMA's vice president of legislative affairs, was recently invited by The TurnAround Management Association, the only international nonprofit association dedicated to corporate renewal and turnaround management, to discuss the topic of medical liability and tort reform during a one-hour debate titled: "The Healthcare Crisis: Is Tort Reform the Right Medicine?"

More than 100 turnaround practitioners, attorneys, accountants, investors, lenders, venture capitalists, appraisers, liquidators, executive

(Continued on page 2)

Dr. Bastulli *(far left) explains to Turnaround Management attendees that caps on noneconomic damages will go a long way to help the state's current medical liability crisis.*

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Touting Tort Reform to Business Leaders *(Continued from page 1)*

recruiters and consultants attended the debate held on Wednesday, Nov. 10 at the Marriott in downtown Cleveland.

Others on the panel included: a medical malpractice attorney, an executive from a health care association, and an accountant with a firm representing businesses. Panelists were asked to discuss current tort reform law in Ohio. The malpractice attorney stated that in his opinion proponents of caps on non-economic damages always try to give the impression that these caps do not mean a lot since the plaintiffs are being compensated for medical bills and expenses. He explained this is not what his cases are about. There is a loss of functionality, loss of sight as well as pain and suffering that must be accounted for somehow. He indicated passage of the tort reform laws were "premature" since they had also established the Ohio Medical Malpractice Commission through the Ohio Department of Insurance (ODI) at the same time "to study the issues." He stated the study should have taken place before the reforms were put into legislation.

Dr. Bastulli responded by stating the AMC/NOMA has had numerous opportunities to meet with the ODI, and it is important to note that not only is ODI putting together data on the issue, but they are also trying to write a proposal for a patient compensation fund as well as looking at other forms of alternative dispute resolution such as mediation or arbitration. In addition, it has been clearly shown that caps on non-economic damages as well as attorney contingency fees do have a definite impact on curbing medical liability costs. Bastulli said, "As far as the current tort reform law goes, there is still a need to test the legislation at the Ohio Supreme Court (OSC) level." He said, "There are 10 cases or more out there working their way through the courts. We need to see if the OSC will uphold this legislation. In the past tort reform had passed in Ohio only to be overturned by a previous OSC. The staffs running these medical liability insurance companies are waiting to see what these court challenges will bring in Ohio."

Then the moderator directly asked Dr. Bastulli: "What are the consequences on quality and access to care due to the medical liability crisis?

Dr. Bastulli stated the AMC/NOMA found escalating costs of medical liability premiums increases the overall costs for the entire health care system. He said access to care is also becoming an issue as physicians retire, leave the state or stop conducting high-risk procedures such as OB/GYN or stop taking ER call. He commented, there are plenty of examples of physicians exiting the state and the ODI tracked more than 180 physicians who have done so. He said many physicians outlined how they reduced their scope of practice or left their practice altogether. There were also examples noted of emergency rooms unable to get physicians to take call. So, he said, quality of care is definitely impacted through lack of access to care.

The attorney quoted studies that showed that there has been no reduction in doctors due to medical malpractice costs, and he also noted that a recent article in our local news indicated that the number of physician licenses are actually going up in Ohio. Dr. Bastulli replied that the numbers published in the news did not reflect the real data and if you drill down on the numbers published by the Ohio State Medical Board, what was quoted in the newspaper was completely incorrect. The numbers as published included podiatrists, massotherapists, anesthesiologist assistants and other health care practitioners, not just physician licensees in Ohio. Bastulli further comments that in fact the AMC/NOMA reviewed the physician number data as published and sent a letter to the editor which was published — that clearly showed that their reported data was flawed.

The attorney stated that most lawyers believe the true solution to this problem is to reduce the percentage of medical malpractice costs by having real insurance reforms in place. He said insurance companies are exempt from antitrust and the sole regulator for many medical malpractice insurance companies is through the ODI in Ohio, which he feels is a department struggling financially with leadership made by political appointments. He then mentioned Proposition 103 in California and indicated this statute, which passed in California, was the real reason rates went down in that state not the fact that MICRA was implemented.

Dr. Bastulli interjected and said that the tort reform bill originally introduced in Ohio was modeled completely after MICRA, the California legislation which has worked to bring down medical malpractice rates. He said one of the main components stripped from the Ohio bill, important in MICRA, was the cap on attorney contingency fees. He indicated the sliding scale set up in MICRA caused more money to go to the plaintiffs and prohibited attorneys from filing frivolous suits. Dr. Bastulli stated that Proposition 103 was targeted to California's auto industry and not implemented until 1988, many years after MICRA started and some time after California saw a trending downward of the medical malpractice rates. In truth, it was the MICRA legislation, not Proposition 103 that brought down the rates in California. Dr. Bastulli closed by stating physicians in Northeast Ohio are in a medical liability crisis and, he believes, caps will ultimately help the situation.

For more information on AMC/NOMA's tort reform initiatives, contact Elayne R. Biddlestone at (216) 520-1000 ext. 321 or via e-mail at ebiddlestone@amcnoma.org ■

CLEVELAND PHYSICIAN

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AMC/NOMA Leadership's Voice Heard Locally and at the State Level

AMC/NOMA Leadership Brings the Lack of MetroHealth Funding to Local Politicians and Editors' Attention

AMC/NOMA President **William H. Seitz, Jr., M.D.,** recently responded to County Commissioners: Jimmy Dimora, Peter Lawson Jones and Tim McCormack's decision to allocate MetroHealth Medical Center only 3 percent of the County's overall $1.3 billion budget via a letter addressing the problem. Within the letter, Dr. Seitz reminds the Commissioners that MetroHealth was promised, expected and deserves an increase in County financial support from $21 million to $42 million this year as a result of the passage of the Issue 15 Levy but instead only received $27 million toward its $585 million annual budget. He writes, "MetroHealth Medical Center provides a safety net to thousands of County residents who do no otherwise have access to healthcare. The potential ripple effect of loss of service at Metro is unthinkable and the commissioners must act responsibly and provide Metro with the funds that were promised to them as a result of the passage of Issue 15." (see letter this page)

The AMC/NOMA president was then interviewed by *Crain's Cleveland Business*. The article quoted Dr. Seitz's letter to the commissioners and also reported that Peter Lawson Jones said he plans to meet with Mr. Sideras, MetroHealth's CEO, "well before the end of the year" to discuss putting on the ballot next year a 0.7 or 0.8 mill levy that would raise about $100 million over 10 years strictly for MetroHealth's capital expenditures. However, that levy wouldn't answer MetroHealth's stated need for additional money now. Commissioner Jimmy Dimora last week reported his hopes that the commissioners will be able to give the hospital enough money for 2005, but indicated increases of $15 million would be difficult to muster because the county already must cut $20 million from its 2005 budget. The AMC/NOMA will continue to follow how the commissioners proceed with the MetroHealth funding issue.

November 29, 2004

The Honorable Jimmy Dimora
The Honorable Peter Lawson Jones
The Honorable Tim McCormack
County Commissioners
C/o County Administrator's Office
1219 Ontario Street
Cleveland, Ohio 44113

Re: Responsibility and Credibility

Dear Commissioners:

There is one in the same answer to all of the following questions:

1) What is the only Level I trauma center in Cuyahoga County?
2) Where is the only burn unit in Cuyahoga County?
3) What institution supports the busiest (80,000 annual visits) emergency room in Cuyahoga County?
4) What institution provides the greatest degree ($125 million) of uncompensated charity care in Cuyahoga County?
5) What institution was utilized by Cuyahoga County's Board of Commissioners as a "poster child" to help pass the Issue 15 levy to raise $137 million annually for health and human services?
6) What institution was promised and expected (and deserves) an increase in County financial support from $21 to 42 million this year as a result of the passage of the Levy but instead only received $27 million towards its $585 million annual budget.

Yes, the answer is the MetroHealth Medical Center. This jewel of an institution daily utilizes the latest technology and innovative skills of its dedicated and renowned staff to work lifesaving and life altering miracles. Examples range from its Life Flight Helicopters where victims are plucked from the grasp of death to its delivery rooms where high-risk babies are brought

FROM THE EXECUTIVE OFFICES

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lovingly to life to its rehabilitation unit where high-tech innovations are teaching spinal cord patients to walk again. As a physician, I have the deepest respect and admiration for my colleagues at the MetroHealth Medical Center. As a parent and patient, I take comfort in hearing the echoes of the Life Flight Helicopter as it passes overhead. As a taxpayer and supporter of Issue 15 I am appalled that the allocation given to MetroHealth Medical Center represents only 3% of the County's overall $1.3 billion budget.

MetroHealth Medical Center provides a safety net to thousands of County residents who do not otherwise have access to healthcare. The potential ripple effect of loss of services at Metro is unthinkable and the commissioners must act responsibly and provide Metro with the funds that were promised to them as a result of the passage of Issue 15.

I speak for 4,000 physicians represented by the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) who unanimously agreed at our recent Board of Director's Meeting that I write to you regarding Metro's funding. The AMC/NOMA board of directors urges the County Commissioners to follow through with the promises made to Metro and provide the $42 million they have requested and are due. County Commissioners should take note. Many physicians were behind Issue 15 and voted for it. Our voice is strong and we expect our elected officials to hear our voice and respond appropriately. Your credibility will be measured in your degree of responsibility in providing the patients of Cuyahoga County the healthcare they voted for and deserve.

Respectfully,

William H. Seitz, Jr., M.D.
President,
Academy of Medicine/Northern Ohio Medical Association

AMC/NOMA Leadership Sends Comments on ODI Draft Rules

The Ohio Department of Insurance filed a rule on data collection with the Joint Committee on Agency Rule Review pursuant to House Bill 215. This legislation requires the Superintendent of the Ohio Department of Insurance to file a rule requiring every authorized insurer, surplus lines insurer, captive insurer, risk retention group, self-insurer, the medical liability underwriting association, if created, and any other entity that provides medical malpractice insurance to risks located in Ohio to report information to the Ohio Department of Insurance at least annually regarding all medical, dental, optometric, and chiropractic claims asserted against a risk located in Ohio, if the claim resulted in a final judgment or settlement in any amount or a final disposition resulting in no indemnity payment on behalf of the insured. The data would have to be filed in a report to the Director prior to May 1 each year and persons failing to file a timely report would be subject to a fine not to exceed $500. The information filed with the Director would be considered confidential and privileged and not a public record.

In a letter dated, Dec. 2, 2004, AMC/NOMA President **Dr. William H. Seitz, Jr., M.D.,** submitted comments regarding the draft rules to the Director of the Ohio Department of Insurance, Ann Womer Benjamin. Dr. Seitz suggested having ODI require data submission from plaintiff attorneys, having ODI include in the rule an item requiring insurers to provide data on insureds who have been named in a claim (sent a claim letter) or complaint that has subsequently been dropped. The letter suggested that ODI specify, for suits, the mechanism of dismissal (ie, dismissal without prejudice or dismissal with prejudice and whether that defendant/insured was dismissed after filing of an affidavit of noninvolvement). JCARR passed the rules without any changes; however, there was an amendment made to HB 425 — which was a bill originally dealing with coal mines was amended to include several unrelated provisions, one of which deals with Medical Malpractice reporting. Continuing law requires medical malpractice insurers to report information to the Department of Insurance at least annually

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AMC/NOMA Leadership's Voice Heard Locally and at the State Level

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on all malpractice claims resulting in a final judgment of any amount, a final settlement, or a final disposition of the claim resulting in no indemnity payment on behalf of the insured. (see Legislative Report on pages 6 and 7 for more information.) The AMC/NOMA will continue to pursue our other suggestions with the Director of the Ohio Department of Insurance.

AMC/NOMA Leadership Provides Continuing Concerns to ODI Regarding the Issue of "Tail" Coverage and Proposes Model Policy Language

In a letter dated, Nov. 24, 2004, AMC/NOMA Secretary/Treasurer and Physicians' Advocacy Committee Chair, **J. Richard Ludgin, M.D., J.D.,** submitted to the Director of the Ohio Department of Insurance, Ann Womer Benjamin, a letter outlining our continuing concerns pertaining to the issue of "tail" coverage in Ohio. The letter, which was approved by the AMC/NOMA Board of Directors, was the direct result of ongoing concerns voiced to the AMC/NOMA from members regarding this issue. During our review of this matter, it has been shown that the policies from the major insurers require a physician receiving a death, disability or retirement (DDR) tail never practice medicine again or, if he does, he risks having his reporting endorsement contract voided. The AMC/NOMA believes that there are many pressing social issues in healthcare that make this waste of talent a travesty. We want to see adoption of a series of exceptions that will not void the tail coverage — such as, working in a free clinic, teaching interns, residents and fellows.

The AMC/NOMA views this issue in the same light as enterprise liability. Physicians who want to work another year or two have been "forced" to retire early because their group is switching insurers and they will have to remain with that insurer for three to five years in order to qualify for a DDR tail. To encourage physicians to remain in practice, the "waiting period" for tail coverage needs to accommodate the realities of the public's need for care.

Draft model policy language, suggested by Dr. Ludgin on behalf of AMC/NOMA included language to have professional liability companies consider a policy that provided for a "No Cost Extended Reporting Endorsement." This suggested policy asks that if the named insured should die or become physically or mentally disabled to where he can no longer practice medicine, the company shall offer, at no additional cost, an extended reporting endorsement with new limits of liability at the limits in effect for the named insured at the time of death or the date on which his disability requires he stop practicing medicine.

Other suggestions made to ODI included that if the named insured elects to retire from the active clinical practice of medicine, the company shall offer, at no additional cost, an extended reporting endorsement with new limits of liability at the limits in effect for the named insured on the date of his retirement. The draft policy submitted to ODI also

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Notes from the First Volunteers in Health Care Teleworkshop

Recently, AMC/NOMA staff participated in the first Volunteers in Health Care Teleworkshop. More than 100 organizations tuned into the conference call sponsored by The U.S. Department of Health and Human Services' new federal program (Free Clinic FTCA Medical Malpractice Program) designed to provide medical malpractice coverage to clinical volunteers at free clinics across the country.

The teleworkshop helped callers determine if this program is appropriate for specific clinicians and explained exactly how to apply for coverage. Shannon Dunne Faltens, JD, from the Department of Health and Human Services' Bureau of Primary Health Care provided information about this new federal program and answered questions. She was joined by Volunteers in Health Care's Gayle Goldin and Paul Hattis, MD, JD, MPH, for a discussion on how this program is likely to affect free clinics across the country.

Participants heard background on how Congress enacted FTCA medical malpractice protection for volunteer free clinic health professionals through Section 194 of HIPAA (Public Law 104-191) by amending Section 224 of the Public Health Service Act (PHS Act) (42 U.S.C 233).

If a volunteer health care professional meets all the requirements of the Program, the related free clinic can sponsor him/her to be a "deemed" federal employee for the purpose of FTCA medical malpractice coverage. The FTCA deemed status provides the volunteer health care professional with immunity from medical malpractice lawsuits resulting from his/her subsequent performance of medical, surgical, dental or related functions within the scope of his/her work at the free clinic.

Claimants alleging acts of medical malpractice by the deemed volunteer health care professional must file their claims against the United States according to FTCA requirements. The payment of claims will be subject to the Federal government's appropriation.

In order to qualify, free clinics must submit an annual FTCA deeming application on behalf of their volunteer free clinic health care professionals to the Department of Health and Human Services (HHS) Health Resources and Services Administration, Bureau of Primary Health Care (HRSA, BPHC) that administers the Program.

HHS will deem a volunteer free clinic health care professional to be a federal employee for the purposes of FTC coverage for medical malpractice claims if the free clinic and health care professional meet certain requirements. According to HHS, a free clinic is a health care facility operated by a nonprofit entity that: in providing health care does not accept reimbursement from any third-party payor (including reimbursement from any insurance policy, health plan or federal or state health benefit program); in providing health care does not impose charges on patients to whom service is provided or imposes charges on patients according to their ability to pay; may accept patients' voluntary donations for health care service provision; and is licensed or certified to provide health service in accordance with applicable law.

Volunteer free clinic health professionals will be deemed a federal employee for the purposes of FTC coverage for medical malpractice claims if the health professional: provides services to patients at a free clinic or through offsite programs or events carried out by a free clinic; is sponsored by a free clinic; provides a qualifying health service without regard to whether the medical assistance is included in the plan submitted by the

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Notes from the First Volunteers in Health Care Teleworkshop

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state in which the health care practitioner provides the service; does not receive compensation for provided services from patients directly or from any third-party payor; may receive repayment from a free clinic for reasonable expenses for an incidentals such as mileage or supplies incurred in service provision to patients; is licensed or certified to provide health care services at the time of service provision in accordance with applicable law; and provides patients with written notification before service provision of the extent to which his/her legal liability is limited pursuant to the PHS Act if his/her associated free clinic has not already provided such notification.

Those services covered include: those that arise from services required or authorized to be provided under Title XIX of the Social Security Act (Medicaid Program) regardless of whether the service is included in the State Medicaid plan in effect for the volunteer free clinic health care professional's work site; those that arise from the provision of medical, surgical, dental or related services at a free clinic site or through offsite programs or events carried out by the free clinic; and occur on or after the effective date that the HHS Secretary approves the deeming application submitted by the free clinic on behalf of its volunteer.

Various program requirements have been instituted before HHS will deem a volunteer for purposes of FTCA coverage for medical malpractice claims. Specific credentialing (licensure, certification, and/or registration) must be met as well as privileging requirements (authorizing a specific scope and content of patient care services).

HHS will go through standard primary and secondary verification sources to deem the applicant.

A free clinic must sponsor each volunteer free clinic health care professional that participates in the Program. A free clinic can sponsor volunteer free clinic health care professional by submitting a FTCA deeming application to the HHS Secretary through the Free Clinics FTCA program. Free clinics can download the deeming application at http://www.bphc.hrsa.gov/freeclinicsftca/application.htm

The program provides protection only from allegations of medical negligence for volunteer free clinic health professionals detailed in the program's information notice. Other free clinic staff and the free clinic corporation are not covered under FTCA. Additionally, the program does not provide protection against perils normally protected by general liability and directors and officers' insurance policies. Free clinics are encouraged to consult with their insurance agents to determine their needs for protection beyond the Program.

For questions directed to the Volunteers in Health organization, contact Gayle Goldin at 877-844-8442, e-mail gayle_goldin@mhri.org or visit www.volunteersinhealthcare.org ■

INSURANCE ISSUES

Malpractice Insurance Premiums: Through The Storm?

By David A. Martin, President, The Premium Group, Inc.

The past three years have been financially treacherous for physicians buying medical malpractice insurance. Prices have been very steep, availability has been scarce and many insurers have failed. Among the surviving carriers who continue to underwrite coverage for physicians, some look more like Rocky Balboa after the fight, rather than before the fight. The good news is that they are still standing.

What are we in for in 2005? The forecast in a nutshell looks like clearing skies and calmer seas, in a word, "stability."

If you have made it through the storm of the last three years, you will likely be entering a time of relative calm and stability. Rate increases should be fewer and farther between and less severe over all.

We will not be seeing an immediate return to the premiums of the late nineteen nineties. Before that happens, competition must strengthen in this market, underwriting results must improve and tort reform must prove its mettle at the level of the Ohio Supreme Court.

The rate increases taken in 2004 have been as follows: ProAssurance 8.6 percent, OHAIS 8.6 percent, The Doctors Company 6 percent, OHIC 17 percent, GE Medical Protective 15 percent, and APA 9.1 percent. Most of these increases were moderate compared with the immediate prior years.

At this time, I know of no planned rate increases scheduled to take effect in Ohio in 2005.

In Ohio, however, there are always changes in the wind. One of the predicted developments is a greatly increased presence of Captives, Risk Retention Groups and new Admitted Insurers. Names such as CARE, HUG, Tri-State Medical and hospital based captives such as Western Reserve Assurance Company will likely grow their policyholder count. With increased availability of reinsurance and the dramatically increased premiums of the past three years, these alternative risk transfer solutions become more viable. They believe there is enough premium now to cover their risks, if they are careful with their underwriting, or offer advanced risk management strategies. A word of caution to the wise before insuring through one of these vehicles: take care to assess the financial wherewithal and the management structure as well as fees of the respective insurer. Most of these entities are not rated and deserve a close look by informed consumers. Some will likely succeed with flying colors, others will not. In almost all of these vehicles that I am aware of, the premiums are similar to those of the standard market insurers (OHIC, TDC, GE/Med Pro, ProAssurance, APA, and OHAIS).

The combination of new names in the market place, hospital sponsored shared risk strategies and an improvement in the underwriting results for the major carriers will all lead to more stability in Ohio in 2005. ■

Ohio State House Report

Prepared by the AMC/NOMA and our lobbyists, Messrs. Mike Caputo and Mike Wise

Ohio Supreme Court Election

Over the last several years, perhaps no government body in Ohio has been more entrenched in controversial issues than the Ohio State Supreme Court. Often times with a very split vote, the Supreme Court has ruled on several important matters which affect the entire state, including issues such as tort reform and how Ohio finances its public schools.

Due to the court's activism on matters such as these, many interested parties have weighed in on how the court should be structured. Historically, AMC/NOMA has supported candidates who have the general support of the business community while unions and trial lawyers have generally supported their opposition.

Although there were several important contests on the November 2, 2004 ballot, it is clear that the three races for a seat on the State Supreme Court were critical. AMC/NOMA, through NOMPAC, aggressively supported the candidates of Chief Justice Thomas Moyer, Justice Terrence O'Donnell and Judge Judith Lanzinger. Due in large part to the hard work of AMC/NOMA physicians and staff, all three candidates that we supported were successful!

Business and Product Liability Tort Reform (SB 80)

While it is too early to fully comprehend the value of a court more understanding of our issues, significant progress on important matters has already been made. Recognizing a more supportive court, the Ohio State Legislature recently passed a bill making sweeping changes to Ohio's Civil Justice Tort System. Am. Sub. S.B. 80 (Stivers-R) drastically changes how civil torts will be managed in this state. While the bill does not specifically address medical malpractice claims, it lays a foundation of ideology that is much more in line with our desire to reign in frivolous lawsuits than any other piece of legislation taken up over the last several years. The passage of civil justice reform was a monumental task for this General Assembly.

The AMC/NOMA has been following the changes and amendments to SB 80 and as a long-standing member of the Ohio Alliance for Civil Justice, a broad coalition of business, insurance and healthcare organizations, the AMC/NOMA has been very supportive of SB 80.

Among the key provisions of Am. Sub. S.B. 80 are:

- Placing limits on the recovery of punitive damages – two times compensatory damages for large employers; for small employers and individuals, the lesser of two times compensatory damages, 10 percent of the employer's or individual's net worth, or $350,000
- Placing limits on the recovery of noneconomic damages – the greater of $250,000 or three times the amount of economic damages up to $350,000 for noncatastrophic injuries; prohibits the use of certain evidence in determining non-economic damages for catastrophic injuries.
- No cap on noneconomic damages for "catastrophic injuries" but judges would be required to review and possibly lower large jury awards based on certain criteria;
- Establishing a 10-year statute of repose for product liability and construction-related claims
- Permitting the introduction of collateral sources of payment to plaintiffs for damages
- Immunity from prosecution for restaurants and food companies that are sued by plaintiffs who blame the restaurant for making them fat or unhealthy.
- Setting limits on the successor asbestos-related liabilities
- Eliminating the consumer expectation test as a stand-alone test for design defect causes of action.

Other pieces of legislation that passed at the end of the year of importance physicians and the AMC/NOMA include the following:

Chicken Pox Immunizations (HB 463) – This bill requires, except in select circumstances, that students be immunized for chicken pox before beginning kindergarten. The House concurred on the Senate's changes and the bill now awaits the Governor's signature. The **AMC/NOMA strongly supported this legislation.**

Mammography Screening (HB 331) – This legislation increases the cap on reimbursement for mammography screening. The Senate adopted an amendment that creates a fee schedule by which health care providers and medical records companies may charge for copying related to medical records.

The bill changes the fees that may be charged for copies of medical records and establishes two fee schedules. The first applies when the request is from a patient or patient's personal representative. The second applies when the request comes from a person or entity other than a patient or patient's personal representative. The bill provides for these schedules to be in effect through December 31, 2008. The bill requires the Director of Health to adjust the fee schedules annually beginning not later than January 31, 2006 to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. **The AMC/NOMA strongly supports this legislation and plans to prepare a revised fact sheet regarding medical records and provide it to our members in the next few weeks.**

Attorney Fee Data Collection (HB 425) – The original intent of this legislation pertained strictly to mine subsistence insurance, however, amendments were made to the bill that ask the Ohio Supreme Court to adopt rules governing data collection on contingency fees that plaintiffs' attorneys receive. Continuing law requires medical malpractice insurers to report information to the Department of Insurance at least annually on all malpractice claims resulting in a final judgment of any amount, a final settlement, or a final disposition of the claim resulting in no indemnity payment on behalf of the insured. HB 425 requests the Ohio Supreme Court to adopt rules of professional conduct that require attorneys who represent persons on medical malpractice claims to file a report with the Department of Insurance or the Department's designee describing the attorney fees and expenses received for the representation, as well as any other data necessary for the Department to reconcile the attorney fee and expense data with other medical malpractice closed claim data received by the Department.

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Ohio State House Report

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The bill defines any information submitted to the Department by an attorney, law firm, or legal professional association pursuant to rules adopted by the Ohio Supreme Court to be confidential and privileged and not a public record. Under the bill, the information submitted is not subject to discovery or subpoena and cannot be made public by the Department of Insurance or any other person. The Department, however, is required under the bill to summarize the information received and to include the information in the annual report prepared by the Department on closed medical malpractice claims. Individual claims data cannot be released in the annual report. The data would be reported to the Ohio Department of Insurance in a confidential format, and in turn the ODI would then issue an aggregate report to the Ohio General Assembly. **The AMC/NOMA strongly supports the provisions of this legislation pertaining to reporting of attorney information.**

Campaign Finance Reform

Another very important matter taken up by this General Assembly was campaign finance reform. Called into a special legislative session by Governor Bob Taft, the legislature made sweeping changes to Ohio's Campaign Finance Laws. Among those most notable and applicable to AMC/NOMA members are:

- *Increasing caps on minimum personal contributions. Current law allows for individual contributions of up to $2500 per election cycle per candidate. With the passage of the campaign finance reform effort, that cap has increased to $10,000 per election cycle per candidate.*
- *Restricting funds that may by used for "issue advocacy" groups. Previously unregulated, the bill imposes several new forms of regulation on third party groups that are formed to discuss issues, not specific candidates. Under current law, corporate funds could be used to finance activity of issue advocacy groups regardless of how close to an election that group's activity is. The new law states that corporate contributions to issue advocacy groups cannot be used on any activity within thirty days of an election for which the group is advocating. Within that thirty-day window, only personal contributions may be used for advocacy activity.*
- *Whereas issue advocacy groups were under to obligation to report its donors, the new law makes all financial activity of a group, both donations and expenditures, reportable to the Ohio Secretary of State.*

There were no substantive changes made to Ohio's limits on contributions to Political Action Committees (PAC's). Therefore, any impact that this bill has on the AMC/NOMA and our PAC–(NOMPAC) activities is expected to be minimal.

Leadership changes at the Statehouse

As the 126th General Assembly is set to begin, there have been several changes to legislative leadership. With terms limits in effect, a new Speaker of the House and Senate President will be sworn in. Jon Husted (R-Kettering) will assume the role of Speaker of the House. In the Senate, Senator Bill Harris (R-Ashland) has won the support to become the next Senate President. Additionally, North Royalton Senator Bob Spada has been named to the majority leadership team in the next General Assembly. Having a member of majority leadership from Cuyahoga County will prove invaluable to this region as the state faces many difficult tasks ahead. Look in your mailbox for a full directory of the 126th General Assembly, to come soon.

On the Horizon for the next General Assembly

The 126th General Assembly promises to be challenging on several fronts. Faced with a two-year deficit projected at approximately $5 billion dollars, legislators will spend the first six months crafting an operating budget bill that reflects Ohio's spending capabilities. The most likely scenario to balance the budget will be a combination of cuts to existing programs (Medicaid is likely to receive significant cuts in state spending) as well as revenue enhancements (extending the 1 cent "temporary" sales tax another two years is being considered. The penny is projected to raise approximately $1.3 billion dollars per year, cutting the projected deficit in half if it remains). The budget process will be the single most time consuming process for the first half of 2005. Given the complexity of this budget in particular, many other significant policy proposals will not be taken up until budget deliberations conclude in June. In addition to the state budget, legislators are expected to take up comprehensive tax reform.

Although the budget and tax reform are certainly going to take up a significant amount of time as those issues are debated, the legislature will review several other important policy matters. AMC/NOMA has submitted a proposal that will create a nonbinding mandatory arbitration for medical malpractice claims. We have reviewed our proposal with legislative leadership and have received positive feedback on our plan. Furthermore, State Senator Kevin Coughlin (R-Cuyahoga Falls), has agreed to serve as the primary sponsor for our proposal. Senator Coughlin's office is currently drafting the bill and we expect it to be introduced early in the next General Assembly.

Due to the nature of the bill, we expect a great deal of opposition, primarily from trial lawyers. We will keep our members fully apprised of developments as they arise, however, our active support both for the bill and Senator Coughlin will be necessary as this bill progresses through the legislative process.

The next session of the General Assembly promises to be exciting and challenging. AMC/NOMA will be the driving force behind what will probably be the most organized effort to mitigate the medical malpractice crisis in Ohio over the next two years. AMC/NOMA members will be asked to play a key role in this effort. Please do not take this request lightly, as your involvement will be critical. You will receive updates on the status of our proposal in the months to come. It will be equally important that our members continue to contribute to NOMPAC. In the meantime, please do not hesitate to contact Elayne R. Biddlestone at the AMC/NOMA at (216) 520-1000 ext. 321 or e-mail ebiddlestone@amcnoma.org with any specific question or comment that you may have. ■

Cuyahoga County Operation Stroke: From Politics to Patient Care

Anthony J. Furlan, M.D.
Chairman Cuyahoga County Operation Stroke
Head Section of Stroke and Neurocritical Care
Department of Neurology
Cleveland Clinic Foundation

Cleveland has been a pacesetter in acute stroke care since intravenous tissue plasminogen activator (IV tPA) received FDA approval in 1996. Early community efforts in stroke included the Academy of Medicine of Cleveland/Northern Ohio Medical Association brain attack guidelines and the Cleveland Health Quality Choice project. Building on this foundation, Operation Stroke and American Stroke Association's (ASA) national initiatives were piloted in five U.S. cities in 1998. Cleveland joined 21 additional pilot cities in 1999. Currently, there are more than 100 cities participating including six in Ohio (Akron/Canton, Youngstown, Toledo, Columbus, Cincinnati, Cleveland).

Each year there are more than 5,000 acute strokes admitted to Cleveland area hospitals. Of those cases, only 2 percent receive IV tPA within three hours of onset, the only FDA-approved treatment for acute stroke. Our reports show more than 1,000 stroke-related deaths occur in Cuyahoga County each year. The objectives of the Cuyahoga County Operation Stoke were: to increase public awareness of stroke warning symptoms by 25 percent; to increase the number of patients reaching an ED within 3 hours of stroke onset to 25 percent; to increase the use of IV tPA to 5 percent; to increase the number of patients presented to an Emergency Department within six hours to 33 percent. To accomplish these goals Cuyahoga County Operation Stroke required participating hospitals to: be involved in stroke CME; to develop standardized dataforms for stroke patients; and, most importantly, to collect outcomes performance data.

The creation of the Cuyahoga County Operation Stroke initiative was not easy and required extensive trust building among the Cuyahoga County physicians and hospitals. Eventually, virtually all Cuyahoga County hospitals became members of Operation Stroke. This unique cooperation was achieved by creating four committees (Education, Marketing, EMS, Medical) which identified issues, suggested participatory solutions and nurtured the development of the initiative in Cuyahoga County. A rehabilitation subcommittee was added last year. Significant accomplishments included: the standardization of EMS field protocols for acute stroke within Cuyahoga County, the development of standardized stroke orders and algorithms for all Emergency Departments, the development of a "Stroke Survivor Guide" for patients and the creation of a community, doctor-friendly, stroke outcomes dataform. The latter was a unique accomplishment of Cuyahoga County Operation Stroke and was overseen by Irene Katzan with the support from grants by Astra Zeneca and Genentech. The initial outcomes data pilot was developed with Gary Hauser and the Stroke Group of Denver, Colorado. Eventually, the data and outcomes effort migrated to the ASA's "Get with the Guidelines" project, linked with the Paul Coverdell National Stroke Registry, which Ohio was one of five pilot states. The Cuyahoga County effort has led to two northeast Ohio "State of Stroke" CME programs each with more than 200 participants and a 2003 Ohio Stroke Summit held in Columbus. In a related effort, the Cleveland Clinic Health System received the 2003 JCAHO Codman Award for systems approaches to the use of IV tPA in acute stroke.

This year the major focus of Cuyahoga County Operation Stroke is to assist local hospitals to become JCAHO-certified Primary Stroke Centers. The goal is to help all Cuyahoga County hospitals with active Emergency Departments to become Primary Stroke Centers over the next two years. Already MetroHealth Medical Center, Lakewood Hospital and University Hospitals have all been certified. The Cleveland Clinic has an anticipated certification date of early 2005. Many of the other hospitals involved with Cuyahoga County's Operation Stroke have indicated they will apply for JCAHO review in 2005 and the organization will be assisting those efforts. There have been preliminary discussions with Cleveland EMS about triaging acute stroke patients to JCAHO-certified Primary Stroke Centers.

Cuyahoga County Operation Stroke represents a multidisciplinary community-wide effort which demonstrates hospitals can overcome local politics and work together to improve the care of patients with stroke. Our success has depended on the efforts of many individuals whom I cannot name all. However, I want to acknowledge Annette DiRosa and Wende Miller of ASA, **Dr. Ronald Savrin** who serves as liaison with the AMC/NOMA and those who have served as committee chairs: Michael Waggoner (Medical), Dr. Dennis Landis (Medical), Cathy Sila (Medical), Chief Christopher Flynn (EMS), John Kubincanek (EMS), Gary Clark (Rehabilitation), Michael Merk (Education), Diane Conaway (Marketing). From its 1999 inception, due to their efforts as well as the entire community's cooperative spirit, Cuyahoga County Operation Stroke has developed into a national role model of regionalized and systematic approaches to stroke care. This "Cleveland experience" was highlighted at the second National Institutes of Health symposium on stroke care in 2002 and has been presented in peer reviewed publications. Our community and our stroke patients should be very proud of these accomplishments.

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Editor's Note: AMC/NOMA staff attends regular meetings and is actively involved in Operation Stroke's initiatives. ■

Collaborative Efforts Improve Regional Emergency Preparedness

Lisa Anderson
Vice President, Member Services, The Center for Health Affairs

The events of September 11, 2001, caused an enormous shift in how we define emergency preparedness. That day brought the realization that the response systems in place at the time could easily be overwhelmed by an incident of such magnitude. As a result, communities across the nation, including here in Northeast Ohio, initiated a concerted effort to ensure they would be prepared.

In our region, hospitals began working with public health, public safety, emergency management and other officials to develop a coordinated regional response plan. While hospitals have long had well-developed and frequently tested procedures for responding internally to emergency events, over the last two years, work has focused on building collaborative arrangements and protocols among hospitals and other community agencies.

This preparedness effort has been supported by a funding stream that was appropriated by Congress beginning with federal fiscal year 2002. The funding has been designated specifically for bioterrorism preparedness efforts, with a portion earmarked for hospitals. The monies are available in the form of grants made by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services. A total of just over $2 million in federal funding has been made available to Northeast Ohio hospitals to date. The distribution of this funding to hospitals is currently underway.

The grant dollars have enabled hospitals to purchase equipment and provide training to their staffs. The Center for Health Affairs (CHA) is the Northeast Ohio regional coordinator and has facilitated the planning process and the flow of federal funding to 28 hospitals in the five counties that comprise the region: Cuyahoga, Lorain, Lake, Geauga and Ashtabula. In order to be eligible for the funding, hospitals have been required to specify how they intend to utilize the grant dollars, and must be consistent with broad guidelines developed at the regional level and approved by the state.

Some outcomes specifically related to the grant funding include the acquisition of personal protective equipment by hospitals; the development of an emergency preparedness operating procedures manual, which was distributed to hospitals by CHA; the acquisition by hospitals of a radio system that can be used for communication during a disaster; and the training of hospital staff in the Hospital Emergency Incident Command System (HEICS), which is a system all hospitals have been encouraged to implement internally for responding to an emergency situation.

Besides developing procedures and purchasing necessary equipment and training, this endeavor has been valuable to hospitals because it has created a sense of cohesion across the region and has strengthened relationships with public health, public safety and emergency management personnel. For example, hospitals have developed an agreement for sharing supplies and equipment in the event of a disaster. Also, over the last two years, hospitals, along with these other entities, have participated in two regional table-top exercises to test and improve the coordinated regional response to a biological event. In addition, at the state level efforts are currently underway to develop a system for quickly and easily verifying the credentials of healthcare professionals who might arrive at a facility, other than where they have privileges or are employed, in order to volunteer their services during a mass casualty event.

At least one more year of federal funding is anticipated to support the continuation of emergency preparedness initiatives. These funds will be useful in furthering the preparedness efforts, but already it is clear that hospitals are more prepared now than they have ever been to meet the needs of the community in the event of a widescale emergency.

Editor's Note: AMC/NOMA is an active participant with CHA in assisting hospital and physician preparedness efforts. ■

The Regional Medical Advisory Committee: Closing the Gap Between Medicine and Public Health

Anna Mandalakas, MD, MS, FAAP
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Medical Director, Cuyahoga County Board of Health

Terry Allan, MPH
Health Commissioner,
Cuyahoga County Board of Health

The profound impact that 9/11 had on our society has been well documented and cannot be overstated. A phase shift in the profile and range of responsibilities of the national public health system occurred in the aftermath. The traditional role of public health has centered on the recognition, evaluation and response to naturally occurring, focused outbreaks of infectious disease. For decades, that work has taken place independent of institutionally-based medical care, to the detriment of both professions. With the reemergence of smallpox now viewed as a potential agent of bioterrorism, the anthrax scares near the

(Continued on page 16)

Medical Acupuncture More Accepted by Physicians and Patients

Robert B. Kelly, M.D., M.S., A.B.F.M., A.A.M.A.

What's All the Excitement About?

Public awareness and use of acupuncture increased in the United States following President Nixon's visit to China in 1972 and *New York Times* reporter James Reston's account of Beijing physicians easing his post-surgery abdominal pain with needles. In the United States there are more than 10,000 acupuncture specialists of whom approximately 30 percent are physicians. In 1993, the FDA reported that Americans were spending $500 million per year and making 9 to 12 million visits for acupuncture treatments. This has increased considerably over the last decade.

What is Medical Acupuncture? Is it Different from Ordinary Acupuncture?

Acupuncture is a very old medical art, and there are many approaches to learning and practicing it. Medical acupuncture is the term used to describe acupuncture performed by a physician trained and licensed in Western medicine who has also had thorough training in acupuncture as a specialty practice. A physician acupuncturist can use one or the other approach, or a combination of both as the need arises, to treat an illness.

How Can Physicians Learn Medical Acupuncture?

The best resource for information on options for training is the American Academy of Medical Acupuncture (AAMA, www.medicalacupuncture.org). The AAMA offers a certification process through the American Board of Medical Acupuncture. Certification involves a minimum of 300 hours of approved CME training in acupuncture, successful completion of a written examination, and a minimum experience of two years of acupuncture clinical practice (at least 500 treatments). The majority of United States physicians who perform acupuncture have received some of their training through UCLA School of Medicine's Helms Medical Institute (HMI, www.HMIacupuncture.com). HMI offers a "Medical Acupuncture for Physicians" course twice a year. The course has "primary care" and "pain management" tracks, with about an 80 percent overlap in the content of the two tracks.

What is the Scope of Medical Acupuncture?

Medical acupuncture is a system, which can influence three areas of health care:

- promotion of health and well-being,
- prevention of illness,
- treatment of various medical conditions.

While acupuncture is often associated with pain control, in the hands of a well-trained practitioner it has much broader applications. Acupuncture can be effective as the only treatment used, or as the support or adjunct to other medical treatment forms in many medical and surgical disorders.

The World Health Organization recognizes the uses of acupuncture in the treatment of a wide range of medical problems, including:

- Digestive disorders: gastritis and hyper-acidity, spastic colon, constipation, diarrhea.
- Respiratory disorders: sinusitis, sore throat, bronchitis, asthma, recurrent chest infections.
- Neurological and muscular disorders: headaches, facial tics, neck pain, intercostal neuritis, frozen shoulder, tennis elbow, various forms of tendonitis, low back pain, sciatica, osteoarthritis.
- Urinary, menstrual, and reproductive problems.
- Physical problems related to tension and stress and emotional conditions; insomnia.

In 1997 a consensus panel convened by the National Institutes of Health concluded that there was clear evidence of acupuncture's effectiveness for postoperative and chemotherapy-induced nausea and vomiting, nausea of pregnancy, and post-operative dental pain. For other conditions, the NIH panel concluded that acupuncture may be effective as an adjunct or alternative therapy. These conditions include addiction, stroke rehabilitation, headache, menstrual cramps, tennis elbow, fibromyalgia, low back pain, carpal tunnel syndrome, and asthma. For chronic conditions, patients will usually need a series of treatments and some require long-term maintenance treatments to maintain gains in symptom control they have achieved.

In clinical practice, acupuncture practitioners often individualize therapy for each patient, and patients may respond (or not respond) to similar or different treatment approaches used by different practitioners. Research on acupuncture's effectiveness has been hampered by the difficulty of efforts to create a "control" treatment, and by attempts to standardize what is, in practice, a more artistic than standardized therapy. The future of research into acupuncture's effectiveness probably lies with comparisons between results of acupuncture and standard allopathic or osteopathic therapy, rather than placebo-controlled trials.

One Physician's Path to Using Medical Acupuncture

Having decided in 2003 that I wanted to learn how to incorporate acupuncture into my clinical practice of Family Medicine, I enrolled in the HMI Medical Acupuncture Course in the Spring of 2004. I began to use acupuncture when I returned from the first intensive six-day segment of the course. I was quickly encouraged to continue by the excellent responses that many patients had to my acupuncture input. Over the next six months, I treated more than 50 people, performing about 170 treatments, while completing the home-study segment of the course. I then took the final 10-day "clinical unit" in late 2004, which cemented and expanded my knowledge and skills. While still a relative novice, I am confident that I can help most of the people who come to me seeking help from acupuncture as a stand-alone or adjunctive therapy. I am planning to pursue further training in the future and to complete the Board Certification process.

Editor's Note: AMC/NOMA members are encouraged to submit articles for inclusion. There are six Cleveland Physician *issues published in: Jan./Feb.; March/April; May/June; July/Aug.; Sept./Oct.; Nov./Dec. The editorial deadline falls the 15th of the month prior to the issue date. Please call (216) 520-1000 ext. 320.* ■

The Pursuit of Smokefree Indoor Air

Garland Y. (Gary) DeNelsky, Ph.D., Chair,
Cuyahoga County Tobacco Control Coalition

Greater Cleveland is moving toward achieving clean (smokefree) indoor air in all public places, including restaurants, bars, and all other public venues. Strong justification for this movement exists from a public health perspective.

Overwhelming evidence has emerged that secondhand smoke (frequently referred to as ETS or environmental tobacco smoke) is not just an annoyance, but a major health hazard. As early as 1975, there was abundant evidence in the scientific literature that ETS is a cause of cardiac and respiratory disease. In 1986 the Surgeon General and the National Academy of Sciences concluded that secondhand smoke causes lung cancer. A pioneering study published in the journal *Circulation* in 1991 concluded that ETS is the third leading cause of preventable death, killing 53,000 nonsmokers in the U.S. each year.1 This number exceeds those killed in highway accidents. This study went on to conclude that for every eight smokers the tobacco industry kills through direct use of its products, it kills one nonsmoker through secondhand smoke.

Separate smoking and nonsmoking sections in restaurants and other indoor environments cannot eliminate an individual's exposure to the toxins from secondhand smoke, according to the Center for Disease Control. Ventilation systems are designed to efficiently circulate air within an enclosed environment, not to filter and clean it. It is virtually impossible to have a truly smoke-free section in a restaurant.

Today, the leading arguments against making all public venues smokefree come from portions of the hospitality industry and fall into one of two categories — economic or ideological. The economic arguments assert that making certain establishments smokefree, such as restaurants, bars and bowling alleys, will hurt businesses. These arguments echo the dire (and unfounded) predictions made before airlines, theatres, grocery stores, and a host of other businesses went smokefree. Researchers studying this issue reviewed 97 studies on the economic impact of smokefree policies in the hospitality industry. They found that all of the best designed studies — those not affiliated or funded by the tobacco industry — reported that smokefree regulations had no impact or a actually had a positive impact on sales or employment.

Ideological arguments maintain America is a free country and eliminating smoking in public places is a step toward losing our freedoms. These arguments ignore that one of the major and most basic functions of government is to provide for the public's safety. If government can issue regulations to ensure that food is properly prepared and safe to eat, and that drinking water is free of dangerous contaminants, why is it an erosion of our freedoms to ensure that the air breathed by patrons and workers in a bar or restaurant is also free of the 53 carcinogens and 4,000 other chemical compounds contained in smoky air?

Throughout the nation and globally, the movement for clean indoor air is gaining momentum. Minnesota is likely to become the nation's eighth smokefree workplace state, joining California, Delaware, New York, Connecticut, Maine, Massachusetts, and Rhode Island. Numerous cities across the nation have also enacted such bans, including New York City, and Columbus and Toledo in Ohio. Entire nations have eliminated smoking in public places — Ireland, Norway, Sweden, New Zealand, and Bhutan have all passed national smokefree legislation.

The Cleveland Clean Indoor Air Campaign officially kicked off in November, 2003. Its goal is to achieve 100 percent smokefree air throughout the greater Cleveland area. Initial goals are to achieve smokefree public places in Cleveland, Lakewood, and Shaker Heights. Progress is being made in all of these areas. Cleveland is a particular challenge for a variety of reasons — its economic problems, the large size of its City Council (21 members), and its complex political landscape. But this past summer, a special governmental Advisory Committee — which included representatives of the hospitality industry — made strong recommendations that Cleveland's City Council enact such legislation, and Mayor Campbell has endorsed clean indoor air. Lakewood seems to be moving rapidly and is drafting legislation at this time. Beachwood also is moving swiftly toward enacting a clean indoor air ordinance and it desires to encourage all of its adjacent suburbs to go smokefree as well, including Highland Hills, Lyndhurst, Orange Village, Pepper Pike, South Euclid, and Shaker Heights. If successful, this move could neutralize the frequently cited (and erroneous) assertion that patrons will flee to adjacent municipalities if they are not allowed to smoke in their home neighborhoods.

More than 11,000 individuals and more than 90 organizations including the AMC/NOMA have endorsed the Cleveland Clean Indoor Air Campaign and its goals.

To join or learn more about the Cleveland Clean Indoor Air Campaign, please visit www.smokefreeohio.org. or contact the AMC/NOMA for more information.

References

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Editor's Note: Dr. DeNelsky has chaired the Cuyahoga County Tobacco Control Coalition since 1995. The AMC/NOMA staff attends regular Cleveland Clean Indoor Air Campaign committee meetings. For more information contact Linda Hale at (216) 520-1000 ext. 309. ■

Discounted Tri-C Class List

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) is pleased to partner with Cuyahoga Community College's (Tri-C) Center for Health Industry Solutions to offer Certification Courses and Continuing Education Unit Seminars at discount prices for AMC/NOMA members and staff.

Earn Certification and CEUS through Cuyahoga Community College's Medical Practice Management Seminars. Day programs are taught by Practice Management Institute (PMI) and focus specifically on medical practice needs. CEUs are offered from PMI, AAPC, and AAMA.

- **Master Collection Through Insurance Processing by PMI (.3 CEU)** Jan. 26 1:00-4:00 pm East 2 Room TBD Price $111
- **Documentation and Guidelines by PMI (.3 CEU)** Jan. 26 9:00 am-12:00 pm East 2 Room TBD Price $111
- **Compliance Officer Training Clinic by PMI (1.2 CEU)** Jan. 27, 28 8:30 am-3:30 pm AMC/NOMA Boardroom Price $371
- **ICD-9-CM Coding Workshop by PMI (.6 CEU)** Feb. 9 8:00 am-3:30 pm East 2 Room TBD Price $187
- **Certified Medical Office Manager by PMI (2.4 CEU)** Feb. 10, 18 8:30 am-3:30 pm AMC/NOMA Boardroom Price $639
- **CPT Coding Workshop by PMI (.4 CEU)** Feb. 16 8:30 am-3:30 pm East 2 Room TBD Price $187

EVENING COURSES (6:00 to 9:00 p.m.) – Receive Certificates of Completion for accelerated medical practice courses taught by local instructors

- **Medical Terminology/Anatomy & Physiology (2.4 CEU)**
  Price $216 East – Jan. 19-Feb. 21 (Monday & Wednesday)
  Westlake – Jan. 25-Feb. 24 (Tuesday & Thursday)
  East – April 4-May 4 (Monday & Wednesday)
- **Medical Coding and Ancillary Services (4.8 CEU)**
  Price $507 East – Feb. 22-April 14 (Tuesday & Thursday)
  West – Feb. 28-April 20 (Monday & Wednesday)
- **Surgical Coding/Modifiers/HCPCS Coding (4.8 CEU)**
  Price $507 West – May 2-June 29 (Monday & Wednesday)
  East – May 3-Jun 30 (Tuesday & Thursday)
- **Medical Insurance Billing for the Medical Practice (1.2 CEU)**
  Price $262 East – March 2-April 20 (Wednesday)
- **Customer Service Workshop for Health Care (.3 CEU)**
  Price $74 East – March 14 (Monday)

Watch your mail for additional class listings. Members and/or their staff will need an exclusive AMC/NOMA course number to register and obtain the discount. For course numbers, call Linda Hale of AMC/NOMA at (216) 520-1000, ext. 309, or e-mail lhale@amcnoma.org. ■

Ohio KePRO to Promote Electronic Records

Alice Stollenwerk Petrulis, M.D., Medical Director, Ohio KePRO

President Bush has stated that Electronic Medical Records (EMRs) would be available to all Americans in 10 years. David Brailer, M.D., has been nationally appointed to take the lead on this project.

The Center for Medicare and Medicaid Services (CMS) has contracted with the Quality Improvement Organizations (QIOs) in each state to promote information technology (IT) in physician office practices and to work with physicians to improve rates on seven quality measures. The quality measures will focus on:

- Immunization
- Diabetes
- Screening mammography
- Colorectal screening
- Hypertension
- Heart failure
- Coronary heart disease

More and more practices are either considering, or have actually taken the important steps to implement these increasingly critical tools. They see the value of an EMR as:

- Improved access to patient information
- Reduction of errors and improvement in quality of care
- Creation of a more efficient office
- Improvement in billing accuracy
- Reduction in transcription costs

A national pilot is already underway in four states as part of this national initiative, which is also called the Doctors' Office Quality-Information Technology (DOQ-IT) Project. Software vendors have already been recruited to assist in this endeavor.

National support has been obtained from physician organizations such as the American Academy of Family Practice and several subspecialties.

The end result of this project will likely be Pay-for-Performance contracts with reimbursement tied to electronic reporting of data. In addition, physician public reporting of quality measures, similar to what is seen on www.medicare.gov for nursing homes, home health agencies and soon-to-be-reported hospitals may follow.

Ohio KePRO is the QIO for Medicare in Ohio. Many physicians throughout the state have already collaborated with us on our ambulatory projects in the last few years and will continue to do so as we move forward in assisting physician offices in the implementation of (EMRs). Physician stakeholder groups, such as the Ohio chapter of the American College of Physicians, have likewise endorsed our efforts on this project.

To prepare for this initiative, Ohio KePRO has added staff from healthcare software companies who have years of experience in the installation of EMRs. The staff is ready to offer consultative services to physician offices at no cost. Ohio KePRO will be able to assist in the selection of an EMR, and offer guidance in implementation to achieve office efficiency.

For those practices that are thinking about, or have recently installed an EMR, and would like further information about this initiative, please contact the Quality Improvement staff at Ohio KePRO at (800) 385-5080. ■

CMS Sets Rates for Physicians

According to the Center for Medicare and Medicaid Services (CMS), effective Nov. 12, 2004, the interest rate for Medicare overpayments and underpayments will be 12 percent. And beginning this month, physician payment rates increase by 1.5 percent. Below CMS offers a few ways to boost your bottom line including:

- "Welcome to Medicare" physical: you can bill for the electrocardiograms in addition to the payment for the physical. They've also allowed you to bill for a more extensive office visit provided at the same time, as long as you can show medical necessity.
- Vaccinations and injections: increased coverage means influenza vaccine payments increase from $8 to $18 — even when the injections are performed on the same day as other Medicare-covered services.
- Expanded access: new coverage for cardiovascular disease and for diabetes.
- Pay restrictions removed: New funding will target low osmolar contrast mediums and clinical costs in certain studies of life-saving investigational devices.
- In-office drug administration: drugs administered in a doctor's office and services related to the use of those drugs will be reimbursed at rates more than 120 percent higher than in 2003. The adoption of 18 new codes allows more chances to bill for these services.
- Part B Drugs: New payment rates will be set at 106 percent of the average sales price based on the most quarterly data from manufacturers.
- Physician "scarcity" areas: A 5 percent quarterly incentive payment to doctors practicing in "physician scarcity areas" listed on the CMS Web site at www.cms.hhs.gov/providers/bonuspayment ■

Results Mixed on Liability Reform Ballot Initiatives

Voters in four closely watched states considered ballot measures to ease the medical liability crisis and strengthen their access to health care:

- In Florida, voters passed Amendment 3, entitling patients in medical liability cases to no less than 70 percent of the first $250,000 awarded, and 90 percent of any damage award in excess of $250,000. However, Amendments 7 and 8, backed by a trial attorneys' group, also passed, including a "three strikes and your licensed is revoked" rule. Those amendments require action by the Legislature before implementation and will be opposed by the Florida Medical Association.
- In a decisive victory, Nevada voters passed Ballot Question 3, placing a hard cap of $350,000 on non-economic damages in medical liability cases, installing a periodic payment plan for damages totaling more than $500,000 and limiting attorney contingency fees. Physicians there are now also only financially responsible for their percentage of fault in a medical liability lawsuit.
- There was a setback for patients in Oregon, where Ballot Measure 35 did not receive enough "yes" votes. Ballot Measure 35 would have reinstated a $500,000 cap on non-economic damage awards in medical liability cases, with an annual Consumer Price Index adjustment.
- Results were mixed in Wyoming. Voters passed Amendment C, which allows the Legislature to set up medical review panels to weed out frivolous lawsuits, while allowing ones with merit to proceed to court. But amid a vigorous campaign funded by a group of personal injury attorneys, Amendment D came up short. That measure would have allowed the Legislature to consider limits on non-economic damages in medical liability cases. ■

SOURCE: *AMA Federation News*

Privacy Rule Complaint Statistics

The HIPAA Privacy Rule provides a mechanism for registering a complaint with DHHS via mail, fax or e-mail. DHHS even provides a Health Information Privacy Complaint Form on its Web site at www.hhs.gov/ocr/privacyhowtofile.htm to facilitate the complaint process. A complaint may be made by anyone who wants to report a HIPAA violation, whether or not the released information related to such individual.

As of April 14, 2004 — one year after most entities were required to be in compliance with the Privacy Rule — the Office for Civil Rights closed nearly 2,700 complaint cases. Nearly two-thirds of the complaints were found not to fall within the scope of the Privacy Rule because they either involved accusations of actions that were not prohibited by the regulation, involved entities that were not "covered entities" as defined by the Privacy Rule or involved actions that occurred before covered entities were required to be compliant. ■

OIG Advisory Opinion Permits Hospital Subsidy of Obstetricians' Malpractice Insurance Premium

The DHHS Office of the Inspector General found that a proposal by a medical center to subsidize the malpractice insurance premium of four obstetricians that provide services in a health care shortage area contained sufficient safeguards to mitigate the risk of violating the fraud and abuse statute. To read the Advisory Opinion No. 04-11, go to www.healthlawyers.org/docs/ask2004/AO_0411.pdf ■

OIG Releases Work Plan Detailing Priorities for Fiscal Year 2005

Each year the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) publishes a work plan announcing where it will focus its resources. Among OIG's agenda items for 2005 are plans to:

- Review the relationship between billing companies and physicians to determine the impact of billing company arrangements on physician billing.
- Examine patterns of physician coding of evaluation and management services to determine whether these services were coded accurately;
- Examine Medicare Part A and Part B claims with overlapping services for skilled nursing facility patients to determine whether duplicate payments are being made to the physicians and the nursing homes for the same patient services;
- Review pathology services performed in physician offices to determine the relationship between physicians who furnish pathology services in their offices and outside pathology companies.

To read the OIG's "Work Plan Fiscal Year 2005" go to www.healthlawyers.org/doc/ask2004/OIG_2005_workplan.pdf ■

Joint Commission's Newly Enhanced Quality Check® Helps Americans Choose Health Care Services

The Joint Commission on Accreditation of Healthcare Organizations launched on July 15, 2004 a new generation of reporting health care information about the quality and safety of care provided in its accredited health care organizations across the country.

The Joint Commission's Quality Check® will provide clear, objective data to individuals that will permit them to compare local hospitals, home care agencies, nursing homes, laboratories, and ambulatory care organizations with others on state and national basis. Further, the Joint Commission will, for the first time, provide hospital-specific information about clinical performance in the care of patients with four major conditions. These include heart attack, heart failure, pneumonia, and pregnancy and related conditions.

Individuals will also be able to determine how health care organizations compare with others in meeting national requirements that help them prevent devastating medical accidents. The requirements specifically seek to avoid misidentification of patients, surgery on the wrong body part, miscommunication among caregivers, unsafe use of infusion pumps, medication mix-ups, problems with equipment alarm systems, and infections acquired in the health care setting.

Consumers can access Quality Check at www.qualitycheck.org and search for health care organizations by name, type, and/or location. Interactive links to information are designed to help individuals better understand how to use and interpret the information presented. Individuals are encouraged to talk with their doctors about the information presented on Quality Check.

Quality Check uses symbols, such as checks, pluses and minuses to make it easy for consumers to compare health care organizations. Quality Check reports include:

- **The organization's accreditation decision and effective date**
- **Health care services provided by the organization that are accredited by the Joint Commission**
- **National Quality Improvement Goals,** which portray the performance of hospitals in caring for patients with heart attack, heart failure, pneumonia, and pregnancy and related conditions. These currently apply only to hospitals.
- **National Patient Safety Goals,** which display the performance of health care organizations in taking specific steps to prevent serious accidents in health care. The Goals and their related discrete requirements are specific to different types of health care settings accredited by the Joint Commission (for example, hospitals, ambulatory care organizations, clinical laboratories).
- **Special quality awards and other distinctions,** such as Magnet Hospital recognition and/or participation in the Hospital Voluntary Public Reporting Initiative
- **Commentary about the Quality Check report,** if the organization chooses to submit one for inclusion
- **Requirements for improvement,** if applicable

The Joint Commission offers a free series of Helping You Choose brochures at www.jcaho.org, or (630) 792-5800. Historical Performance Reports will continue to be available at the Quality Check Web site, www.qualitycheck.org. For consumers unable to access Quality Check online, call the Joint Commission's Customer Service Center at (630) 792-5800, 8:30 a.m. to 5 p.m. CT, during weekdays. ■

United States Postal Service

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Full Name	Complete Mailing Address
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d. Free Distribution by Mail (Samples, complimentary, and other free)	(1) Outside-County as Stated on Form 3541	40	57
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	(3) Other Classes Mailed Through the USPS	0	∅
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f. Total Free Distribution (Sum of 15d. and 15e.)		278	372
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I ce[illegible] furnish[illegible] complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
6. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form 3526, October 1999 (Reverse)

THE NEW NAME IN HOSPICE CARE

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Kathy Stahl, CHPN, RN
Certified Hospice Nurse

Formerly VNA Hospice. An Agency of the Visiting Nurse Association.

AMC/NOMA Leadership's Voice Heard Locally and at the State Level

(Continued from page 3)

included conditions and exceptions that would apply to the extended reporting endorsements applicable to physicians who retire. The suggested draft indicates that retirement shall mean the complete cessation from the practice of clinical medicine for a period of at least five years except:

i. Physicians may engage in medical research that does not involve patients.
ii. Physicians may teach in a non-clinical (nonpatient care) setting, e.g., classroom.
iii. Physicians may engage in claim review for the state or federal government for private or other "public" health insurer.
iv. Physicians may engage in such activities as:
   1. JCAHO Survey (for the JCAHO or for a private organization)
   2. Any other form of consultation or employment that involves the use of their medical knowledge but does not include any form of patient care.
v. Physicians may provide clinical services for government sponsored and independent free clinics so long as:
   1. Professional Liability coverage is afforded to physician by that entity.
   2. Any income derived from this activity is de minimus (less than $100,000/year).
vi. Physicians may provide clinical services in the form of supervising physicians-in-training (interns, residents, and fellows) so long as they Professional Liability coverage is afforded by the organization or institution that provides the setting for the intern, resident or fellow training.

There is no assurance that ODI will consider requesting that medical liability companies in Ohio adopt this model draft policy, however, the AMC/NOMA leadership plans to meet with the Director of ODI to pursue this issue. We will keep our membership apprised of any developments. *(Questions? Contact the AMC/NOMA executive vice president/ CEO at (216) 520-1000, ext. 321 for more information on this issue.)*

(For related story on Volunteer in Health Care Teleworkshop see pg 4.) ■

The Regional Medical Advisory Committee: Closing the Gap Between Medicine and Public Health

(Continued from page 9)

end of 2001 and the emergence of global epidemic potentials related to West Nile Virus, SARS, and Avian Influenza, the need to close the gap between the independent and often parallel paths of medicine and public health was long overdue. These events served as a catalyst for rapid local change in meeting this need.

In November of 2001, the local health departments in Cuyahoga County, in coordination with community medical and academic partners from the Cleveland Clinic Foundation, University Hospitals of Cleveland, MetroHealth Medical Center, the Academy of Medicine of Cleveland/Northern Ohio Medical Association, the Center for Health Affairs, the Cuyahoga County Coroner and Case School of Medicine formed the *Cuyahoga County Medical Advisory Committee.* This committee, comprised of public health and medical experts, has become a forum for discussing a range of topics related to infectious disease control and is now recognized as the *Regional Medical Advisory Committee on Bioterrorism Preparedness.*

Some of the initial work of this committee involved the planning of the Smallpox Vaccination Campaign for area public health and medical response staff which included discussion on the implications of a mass vaccination campaign. The design of the prescreening process for potential vaccinees coordinated by this committee was critical to minimizing adverse events related to the administration of the smallpox vaccine, including issues surrounding HIV exposure, pregnancy status and previous Smallpox vaccination.

An educational conference designed to orient medical workers and safety forces about the vaccination campaign was very successful. Committee physicians were also actively involved in vaccination clinic logistics to assure safe and efficient distribution of vaccine to recipients and provided 24/7 coverage for consultation on vaccination-related issues in the weeks following vaccination. All of these issues have implications for pandemic influenza planning and the entire process has forged strong partnerships between medicine and public health that will serve both professions well into the future.

The emergence of SARS raised concerns about nosocomial transmission through an unrecognized case. The Medical Advisory Committee convened on a number of occasions to discuss the need for increased surveillance in all hospital ICU's for patients with respiratory symptoms. In response to these concerns, a conference was planned for December 11, 2003. "SARS 2004: Bracing for Its Return, Regional Preparedness", which provided an opportunity for professionals across multiple disciplines to increase their public health and patient management skills based on lessons learned from the SARS 2003 outbreak. These discussions about SARS brought about further concerns regarding the limitation on movement to contain and control an infectious disease outbreak, resulting in a community plan to address issues related to quarantine.

Most recently, the committee discussed the issues surrounding the current influenza season, including challenges around the shortage of vaccine. It was agreed that a unified message on illness prevention will be important when flu cases start to increase. Promoting messages on "Cough Etiquette, "How to Stay Healthy" and "When to See Your Physician" will be very important addressing hospital surge capacity issues this winter.

The technical knowledge and insight of this group has served Northeast Ohio well in confronting the emerging challenges of medicine and public health. To optimize the impact of this valuable resource, highlights of the Medical Advisory Committee's work will be included in a future *Cleveland Physician* magazine.

For additional information about the Medical Advisory Committee or other public health issues, please contact the Cuyahoga County Board of Health's Rebecca Hysing at (216) 201-2001 ext. 1602, rhysing@ ccbh.net or visit www.ccbh.net as well as AMC/NOMA (216) 520-1000 ext. 321 or e-mail ebiddlestone@amcnoma.org ■

Thinking About Retiring?

If you are considering retiring from your practice we need to hear from you. Why? Your benefits!

As a retired member you will continue to receive many of the benefits of membership, including dues-exempt membership at a "retired" status, access to staff, access to the AMC/NOMA Web site (www.amcnoma.org), eligibility for AMC/NOMA 50 year award, and your name in the AMC/NOMA physician directory so you can stay in contact with your colleagues.

Here are some helpful hints:

- We can provide you with information that will be beneficial to you whether you are selling or closing a medical practice.
- It would also be very helpful for the AMC/NOMA to know where your patient records are. We get many phone calls from patients trying to locate their medical records from a retired physician and can handle these inquiries for you.

Here are the options for retired membership:

- Your AMC/NOMA dues must be current.
- If you retire before May 1, 2005, you pay no 2005 dues. You will have "retired" status.
- If you retire after May 1, 2005, you will need to pay your 2005 dues, then you will be dues exempt in 2006.

For more information about closing a practice or to change your membership status, contact Linda Hale in the Membership Department at (216) 520-1000 ext. 309. ■

Not Quite Retired But Cutting Back on Hours

AMC/NOMA offers part-time membership to physicians 66+ years of age working less than 20 hours per week and/or less than 40 hours per week. Contact membership at (216) 520-1000 for information. ■

New Group Members Add to Regional Presence

Increasingly more physicians are realizing in the struggle for medical liability reform, increased reimbursements and patients' access to care, strength lies in numbers and if today's doctors want to see real change transpire, all doctors — regardless of their affiliation — must band together.

In 1999, the separation of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) (founded in 1824) from the state medical association, allowed for a strong working relationship on state legislative issues between the Ohio Podiatric Medical Association and the AMC/NOMA.

Last October 1, 2004, 90 active members from the Northeastern Ohio Podiatric Academy joined more than 4,000 MD/DO members of the AMC/NOMA as group members.

William H. Seitz, Jr., MD, orthopedic surgeon and President of the AMC/NOMA, said the decision to add podiatrists to the county's medical society was part of other major changes in the Academy of Medicine Cleveland's membership structure. He explained, this change made it possible to disengage from the state medical society in 1999 and become an independent medical society. He said the AMC/NOMA leadership decided to do this because it's a "membership-driven" association and the Cleveland physicians wanted group membership to better reflect the practice of medicine in the 21st century. Then, he explained, the AMC/ NOMA leadership created a new group membership category for hospital medical staffs and medical group practices. Allowing podiatrists to join was a direct result of the AMC/NOMA leadership working with Cleveland's hospital medical staffs. He explained since podiatrists are full members of these hospital medical staffs, with all the rights and privileges of MD/DO physicians, it made sense to allow podiatrists membership in the AMC/NOMA.

> *"As long as we all put our patients interests first, we are all working together."*
> *– William H. Seitz, Jr., M.D.*

The measure of success Dr. Seitz hopes to realize, within a year of admitting the AMC/NOMA's newest membership group, is active involvement, not just dues-paying members. For example, he'd like to see the group become active on committees, in programs and in CME seminars. He said he's already worked closely with the Ohio Podiatrist Medical Association (OPMA) in the past on legislation. His hope is the AMC/NOMA's involvement of podiatrists becomes a national model for other county medical societies.

He said, "We are facing the same problems, the same issues…malpractice increases, fee decreases, patients losing access to doctors, we are all colleagues facing the same threats to all of our patients. All doctors have one thing in common. We are all just taking care of our patients." ■

CLASSIFIEDS

PHYSICIAN OPPORTUNITIES - Full- or Part-Time in medicine, general surgery, cardiothoracic surgery, pediatrics and OB/GYN. $110–250K, never on call, paid malpractice. Physician Staffing, Inc., 30680 Bainbridge Rd., Cleveland, OH 44139. (440) 542-5000, Fax: (440) 542-5005, E-mail:medicine@physicianstaffing.com

MEDICAL OFFICE SPACE 15900 Snow Road, Brook Park. 900 sq. ft. furnished, 1300 sq. ft. unfurnished. MRI PT in building. 2 years old. call (440) 816-2735

INTEGRATIVE MEDICINE CLINIC in Middleburg Heights seeks open-minded physician to join three "hands-on" DOs, two acupuncturists, one PA. New 7,000 sq. ft. office. Cash-based (no insurance hassles). Practice is 40% peds. Competitive, incentive-based compensation. Will train. See www.osteomed.com or call (440) 239-3438.

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Developing New Directives to Address Medical Liability and Patient Safety in Northern Ohio

FRIDAY, MARCH 4TH, 2005
EMBASSY SUITES, INDEPENDENCE, OHIO
JOINTLY SPONSORED BY: THE ACADEMY OF MEDICINE OF CLEVELAND/NORTHERN OHIO MEDICAL ASSOCIATION, (AMC/NOMA), THE ACADEMY OF MEDICINE EDUCATION FOUNDATION (AMEF), THE CLEVELAND ACADEMY OF OSTEOPATHIC MEDICINE (CAOM), AND SAINT VINCENT CHARITY HOSPITAL.

PROGRAM FORMAT:

9:00 a.m. – 9:15 a.m. – Opening Remarks

William H. Seitz, Jr., M.D.,
President, Academy of Medicine of Cleveland/ Northern Ohio Medical Association (AMC/NOMA), and
George Thomas, D.O.,
President of the American Osteopathic Association.

Program Moderator: Dr. William H. Seitz, Jr., AMC/NOMA President and AMEF Board Member.

9:15 a.m. – 10:00 a.m. Medical Liability Insurance Update

Ms. Ann Womer-Benjamin, J.D.,
Director of the Ohio Department of Insurance,

- Update on the Ohio Department of Insurance initiatives — update on current liability insurance market and final report of the Ohio Medical Malpractice Commission.

10:00 a.m. – 10:45 a.m. Legislative Advocacy Initiatives – State Legislative Update (Panel)

Mr. Michael Wise, J.D.
McDonald, Hopkins Burke and Haber, and
Mr. Michael Caputo
AMC/NOMA lobbyists

What is going on in Columbus relative to medical liability issues

- Update on legislation of importance to physicians
- Discussion on how physicians can work with politicians to advocate for their issues

The Honorable Kevin Coughlin – Ohio Senate

- Overview and purpose of proposed alternative dispute resolution legislation in Ohio

10:45 – 11:00 a.m. – BREAK

11: 00 a.m. – 12 noon – Advantages of Alternative Methods to Litigation

George F. Lee, M.D. CEO and President,
Physicians Reimbursement Fund (RRG),
California Pacific Medical Center, San Francisco, CA

12:00 noon – 12:45 p.m. LUNCH

12:45 – 1:45 p.m. Bridging Medical Liability and Patient Safety

William Sage, M.D., J.D, Professor of Law,
Columbia University, New York, NY

1:45 – 2:45 p.m. The How and When of Communicating Unexpected Outcomes

Gerald Hickson, M.D.
Associate Dean for Clinical Affairs,
Director, Vanderbilt Center for Patient and Professional Advocacy

2:45 p.m. – 3:00 p.m. - BREAK

3:00 – 4:00 p.m. The Potential of Health Information Technology to Reduce Errors and Reduce Premiums

Barry Chaiken, M.D.
Chief Medical Officer, American Board of Quality Assurance Utilization Review Physicians – Boston, MA

4:00 – 4:30 p.m. - National Health Policy Update Patient Safety and Tort Reform Initiatives at the Federal Level — What Can We Expect from the 109th Congress?

The Honorable William Frist, M.D.
United States Senate (INVITED)
The Honorable Steven LaTourette
United States House of Representatives (INVITED)

4:30 – 5:00 p.m. CLOSING REMARKS – WRAP-UP What Needs to be Done and Where Do We Go From Here?

William H. Seitz, Jr., M.D.
President, Academy of Medicine of Cleveland/ Northern Ohio Medical Association (AMC/NOMA), and
George Thomas, D.O.
President of the American Osteopathic Association.

St. Vincent Charity Hospital designates this educational activity for a maximum of 6.5 Category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity. The cost for residents is $25, AMC/NOMA or CAOM members is $50 and nonmembers and other healthcare professionals is $75. See the enclosed brochure in this edition of *Cleveland Physician* to register.

AMC/NOMA "Solving the Third-Party Payor Puzzle" 2004 Seminar

The annual AMC/NOMA " Solving the Third-Party Payor Puzzle" Seminar was held on November 10, 2004. Speakers were from organizations such as: Athem Blue Cross and Blue Shield, Palmetto GBA, Medical Mutual of Ohio, the Bureau of Health Plan at the Ohio Department of Jobs and Family Services.

Presenters provided information on the Direct Deposit plan that is now available. Applications were provided along with informative packets, which also addressed important phone numbers and Web sites. Our insurance representative also explained that due to identity theft, Identification Cards would change. Anthem has a Clinical Account Pharmacists on staff that is willing to meet with providers to discuss new medication and ways to increase patient compliance. Also discussed was a new company called CAQH. CAQH is a Universal Credentialing Data Source. CAQH provides an easier way to credential physicians. "One physician, One application, One Source", is the company's motto.

From left: Kathy Moore and Dottie Justice, both ombudsmen of bureau health plans with the Ohio Department of Jobs and Family Services, found the AMC/NOMA's recent Third Party Payor seminar a good opportunity to present the Bureau's basic billing training manual to attendees.

Palmetto GBA covered common denials and reasons, as well as solutions to these problems. Palmetto also offers federal incentives for providers that practice in underserved areas. The Health Professional Shortage Areas (HPSAs) incentive provides a 10 percent bonus payment paid quarterly to the physician in this area. Another incentive program called Physician Scarcity Areas (PSAs) provide a 5 percent bonus payment for services rendered by physicians in PSA-designated geographical areas. The government representative also covered the new Medicare Drug Program. The Palmetto representative reviewed the telephone appeals process line as well as various training programs for their providers.

From left: Medical Mutual of Ohio's provider service representatives, Diana Irvin and Melissa Stary, used the AMC/NOMA's Nov. 10 seminar to relay information regarding the plan's modifier updates, global surgery rules, reimbursements for blood draws as well as case management.

Medical Mutual of Ohio discussed the importance of provider-to-provider relationships by offering attendees the opportunity for Medical Mutual of Ohio representatives to come to their office to meet with staff members, answer any question, and provide training regarding billing issues. *The Professional Provider Manual* is now offered on disk, which should make it easier and quicker for providers to find information. Medical Mutual Current Topics included, modifier updates, global surgery rules, reimbursement for blood draws and many other topics.

From left: Michael F. Galloway and Cheryl Donahue, both with Anthem Blue Cross and Blue Shield, shared with seminar attendees relevant information regarding the company's direct deposit plan and credentialing services.

The Ohio Department of Jobs and Family Service's briefly shared information regarding their new Interactive Voice Response System, designed to access client information, claim status, payment status and other valuable information. For more information contact Taunya Rock at AMC/NOMA (216) 520-1000. ■

Building a Financial Plan

Our lives are filled with commitments, both in your practice and family. Securing your future is probably the most important commitment you will make, but when it comes to doing the actual planning necessary to secure your future, many put if off.

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AMC/NOMA Leadership Continues to Meet with Medical Staff Around the Region

Dr. James Lane, (right) immediate past president of AMC/NOMA, outlines to Huron Hospital medical staff members the AMC/NOMA's efforts to promote medical liability reform and the organization's instrumental role in the 2004 Ohio Supreme Court outcome while Dr. Raja Shekar, (left) chief of staff, looks on.

From left: Dr. John Bastulli, AMC/NOMA vice president of legislative affairs, poses with Lakewood Hospital's Chief of Staff, Dr. Marvin Shie III, prior to his Nov. 11 presentation to medical staff.

Colleague's Corner

Recognizing outstanding AMC/NOMA members for their honors, awards and achievements, in addition to their work to spread health and wellness messages to the community.

Dr. Kodish Takes Clinic Post

AMC/NOMA member, **Dr. Eric Kodish** of Rainbow Babies and Children's Hospital is the new chairman of the Cleveland Clinic's department of bioethics in clinical research division. Kodish is the first physician to lead the department. He started in October 2004 after three years as founding director of the Rainbow Center for Pediatric Ethics and more than a decade as an attending physician in hematology/oncology at Rainbow, part of University Hospitals of Cleveland. Kodish is a professor of bioethics, pediatrics and oncology at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Dr. Thomas Creates New Center for Space Medicine

Last October, AMC/NOMA member, **Dr. James D. Thomas, M.D.**, section head of The Cleveland Clinic's Cardiovascular Imaging, created The Center for Space Medicine in conjunction with Peter R. Cavanagh, Ph.D.Sc., chairman of the Clinic's Department of Biomedical Engineering. The Center for Space Medicine researches medical problems experienced by humans during long-term space flight. The center works closely with engineers and scientists at Cleveland's NASA Glenn Research Center. ■

Mark Your Calendar

- Mark your calendar for **Sunday, Jan 30** for a Wine Tasting at Club Isabella from 5 to 7 p.m. RSVP by Jan. 21 required to Linda Hale at (216) 520-1000 ext. 309. Member and spouse cost is $20 per person, residents and medical students cost is $15 per person. Hor d'oeuvres, a fine selection of wines and dialogue with a local wine connoisseur included with fee.

- Mark your calendar for **Friday, March 4, 2005** for a full-day seminar titled, "Developing New Directives to Address Medical Liability and Patient Safety in Northern Ohio." The seminar will take place at Embassy Suites in Independence.

- Mark your calendar for **Friday, April 29, 2005** for the next AMC/NOMA Annual Meeting. Ohio Supreme Court Chief Justice Thomas J. Moyer will be the keynote speaker. The event is schedule to begin at 7 p.m. at the Ritz-Carlton Hotel in Cleveland. More information to come in subsequent issues of the *Cleveland Physician.*

- Mark your calendar for **Monday, August 8, 2005** for the 2nd Annual Marissa Rose Biddlestone Memorial Golf Outing. ■

Dr. Bastulli Represents AMC/NOMA on WCPN's Radio Program Titled: "Scales vs. Scalpels"

Dr. John Bastulli, VP of legislative affairs for the AMC/NOMA, recently debated J. Michael Monteleone, personal injury attorney at the Cleveland law firm of Jeffries, Kube, Forrest & Monteleone Co., L.P.A. on WCPN's (90.3 FM noncommercial public radio) program hosted by Dave Pignanelli.

The topic: "Scales vs. Scalpels" focused on the state's medical liability crisis and asked who's to blame: trial lawyers, doctors or insurance companies? Some of the questions posed to the interviewees by Mr. Pignanelli included: Where is Ohio as far as its version of tort reform? When caps were placed did insurance companies freeze their rates for doctors? What is the dollar amount awarded by a jury that's deemed excessive and requires a judge to step in?

Dr. Bastulli did an excellent job in representing the AMC/NOMA and explaining to the listening audience that states which have enacted "meaningful tort reform" have medical liability rates that are one-third less than Cuyahoga County's current rates. He deflected the common notion that insurance companies are increasing their rates to compensate for poor financial investments in the late 1990s by explaining the insurance industry is heavily regulated and, by law, is only able to invest a small percentage into high-risk funds.

He said while the insurance industry saw financial losses, as many investors did in the late 1990s, they were modest. He said the reason doctors have not seen substantial decreases in medical liability rates yet is because the legislation needs to mature and "meaningful tort reform" needs to be enacted in the state.

Dr. Bastulli deciphered for the audience the difference between "tort reform" and "meaningful tort reform" by explaining we need caps on pain and suffering, limits on attorney contingency fees, expert hearing panels and to establish a mediation system. ■