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AMCNO President Dr. Levy Participates in Program to Discuss Hospital Consolidations

Several experts from the healthcare field came together in January to discuss hospital consolidations, acquisitions and mergers in Northeast Ohio through the *ideastream* talk show, "The Sound of Ideas."

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) President, **Dr. Matthew Levy,** was invited to the join the conversation. The other participants were **Bill Ryan,** President and CEO of The Center for Health Affairs; **Sarah Jane Tribble,** Health Reporter for *ideastream*; **JB Silvers,** Professor of Health Care Finance at Case Western Reserve University; and **Martin Gaynor,** Professor of Economics and Health Policy, Carnegie Mellon University. **Mike McIntyre,** Host/Producer of the program, served as moderator.

During the hour-long program, the panel discussed the history, pros and cons, and logistics behind the hospital consolidations that have been occurring in the Cleveland area for the last several years.

McIntyre provided some background information to start the conversation, commenting on how there used to be a dozen community hospitals in Northeast Ohio, but now many of them have merged with other systems. And, nationwide, records were broken in 2014 for mergers and acquisitions—they were up 25% over the previous year, with 1,307 deals. McIntyre went on to say that he was looking to discuss what's driving this continuing trend of consolidations in health care, the role of the Affordable Care Act, independent physician practices, and what consolidations will mean for patients (i.e., how they impact quality and cost).

(Continued on page 5)

Medical Marijuana Debate Begins

The Ohio House has created a committee to review medical marijuana, a group that includes representatives from the medical field, law enforcement and medical marijuana advocates.

Rep. Kirk Schuring (R-Canton) said all the meetings would be at the Statehouse and all members of the task force would be able to invite people to speak, while the task force would also consider input from the general public. Rep. Schuring said he expected people from outside of Ohio participating in the discussion.

The task force held its first meeting on Jan. 28 at 3 p.m., and meetings will continue throughout February and March. The group's goal is to evaluate what the best action would be for the state to take on the issue. Representatives on the panel include physicians and legislators along with other key appointees.

Over in the Ohio Senate, Senators David Burke (R-Marysville) and Kenny Yuko (D-Richmond Heights) are holding public town hall meetings around the state to gather input. Their first meeting was held in Cleveland on Saturday, January 30, at the Wolstein Center. The AMCNO president-elect, Dr. Robert Hobbs, was present at the Cleveland hearing to provide testimony on behalf of the AMCNO.

Dr. Robert Hobbs, AMCNO President-Elect, outlines the AMCNO position on medical marijuana at the Senate Town Hall meeting in Cleveland.

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AMCNO LEGISLATIVE ACTIVITIES

AMCNO Outlines Position on Medical Marijuana at Town Hall Meeting in Cleveland

Dr. Robert Hobbs, AMCNO president-elect, attended the medical marijuana town hall meeting in Cleveland in order to present the AMCNO viewpoint on the issue of medical marijuana. Senator David Burke began the meeting by stating that the hearing was being held along with several other planned hearings because the Senators want to hear views from others from around the state so that they have some information on this topic as they move forward with their discussions in the legislature. Senator Kenny Yuko also provided opening comments stating that he has done some research on this issue and he believes that there is a chance to change the quality of life for some people. He stated that there are misconceptions about this issue and there is a willingness from people on both sides of the aisle in Columbus to work on this issue.

Several families with children testified first, outlining how they believe that having the ability to use some form of medical marijuana to treat children with certain diseases could be beneficial and helpful. Others cited studies and examples of how medical marijuana has already helped their children with epilepsy and seizures. Others stated that there is ample evidence available that whole plant cannabis should be made available for use.

Dr. Robert Hobbs testified on behalf of the AMCNO citing the AMCNO mission statement, which is *to support physicians in being strong advocates for all patients and to promote the practice of the highest quality of medicine.* He stated that in keeping with our mission statement, the AMCNO believes that it would be inappropriate to legalize a substance for medicinal purposes before more scientific research has been conducted. While there have been some studies which show the potential benefits of marijuana for some medical conditions, the AMCNO believes that further scientific evidence is necessary in order to support the use of this drug as a suitable alternative for the treatment of certain illnesses. Therefore, the AMCNO believes that marijuana should be subject to the same research and study as any other type of medicine, and we do not oppose additional clinical research.

In his testimony Dr. Hobbs stated that as the debate on this issue continues in Ohio and at the federal level, the AMCNO has agreed to:

- Oppose the recreational use of marijuana.
- Support clinical research to explore the potential risks versus benefits of using marijuana or its component chemicals to treat specific medical conditions.
- Support controlled medical use of pharmaceutical grade marijuana or its component chemicals for treatment of those conditions which have been evaluated through Institutional Review Board (IRB) approved clinical research studies and have been shown to be appropriate.
- Support the review and possible change of marijuana's status from a federal Schedule I controlled substance with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines.
- Support setting limitations on marijuana prescribing rights, if permitted, to physicians (MDs and DOs).
- Oppose the legalization of marijuana except in the instance of appropriate evidence-based use approved by the FDA.

Dr. Hobbs wrapped up his testimony commenting that the topic of medical marijuana is an important issue for both physicians and the public, and it is critical that physicians and the public become educated about the issues related to medical marijuana and the legalization of marijuana. And, as the debate continues on this topic at both the state and federal level, the AMCNO is committed to working with all parties on this issue and providing our input as necessary.

In other testimony, concerns were raised about how the widespread use of medical marijuana could impact patient safety before scientific study and testing have been completed. Suggestions were made that there should be restricted access to only specific diagnoses for patients and, if allowed, medical marijuana should only be prescribed by a trained physician, dispensed by a licensed pharmacist, tracked via the OARRS system in the state of Ohio, and be limited to only a select group of disease states. Law enforcement representatives expressed concerns as well, noting that if medical marijuana is approved it should be like all medicines—even without FDA approval the state should have it in patch or pill form—and take the THC out of it so that patients will still receive the medicinal benefits, but without impairment, addiction, use by youth and those wanting to get high.

AMCNO Continues to Meet with Legislators Regarding HB 216 – Opposition Testimony Given by Physician Organizations Before the House Health and Aging Committee

In February, opponent testimony on HB 216 was given before the House Health and Aging Committee on HB 216—the bill which would allow advanced practice registered nurses to practice independently, without a standard care arrangement with a collaborating physician. In addition, Senator Shannon Jones (R-Springboro) has now introduced a companion bill in the Senate—SB 279.

Opponent testimony was offered by physicians representing a coalition, which includes the AMCNO. Testimony provided to the House Health and Aging Committee by several physicians indicated that HB 216 would likely not do much to help address the problem of having primary care providers in underserved, rural areas. It could also hamper the state's efforts to cut down on the over-prescription of opioid pain medication.

It was also suggested that the formulary for what drugs APRNs can prescribe be kept, but modified so that it's exclusive, not inclusive—meaning a panel would decide what drugs they cannot prescribe. Others testified that doctors receive a lot of training about the root causes of conditions and the function of the human body that nurses do not, and that it is important for medical professionals to continue to collaborate together, and the requirement for APRNs to have a collaborating physician ensures that. In addition, comments were made that it was not necessary to expand the ability to order drugs to certified registered nurse anesthetists, or CRNAs, because they will always be working with the close supervision of an anesthesiologist or a surgeon.

The AMCNO is concerned about this legislation, and we believe it takes our state in the wrong direction. While physicians value the professional abilities that APRNs bring to the healthcare team, they are not a replacement for us as physicians and the care we provide to our patients. Physicians are not interchangeable with APRNs; and we should be the leaders of the healthcare team. Patients deserve the best care possible, and that care is optimally coordinated by a physician.

AMCNO President-Elect Dr. Robert Hobbs spends a moment with Rep. Sarah LaTourette following a meeting with her to discuss HB 216.

The AMCNO has joined other medical associations across the state in urging its members to send letters to the legislature in opposition of HB 216. We are asking our members to get involved by emailing, calling or reaching out to your elected official to have a one-on-one meeting on this issue. The APRNs have been holding town hall meetings all over the state with elected officials for the past few months, telling them they are able to do the same job as physicians can do. The AMCNO and other medical associations from around the state have been working tirelessly on this issue, but it is time that physicians get more involved.

It is also just as important to call your elected official or request to meet with them in person to express your concern for this bill. To learn more about the bill and to send an opposition letter, go to our website home page for more information.

AMCNO Asks Ohio Senate to Consider Changes to HB 110

House Bill 110, failure to stop after accident-increase penalty, was introduced in March 2015. Recently, an amendment was introduced by Sen.

Bill Seitz (R-Cincinnati) and was approved in the Senate Criminal Justice Committee that mandates Emergency Medical Services or the Fire Department report the name and address of an overdose victim to requesting law enforcement when naloxone is administered by EMS/Fire. The purpose behind the amendment in this bill appears to be to provide protections for EMS/Fire against HIPAA violations in these circumstances and to enable law enforcement to question overdose victims about the drug dealers from whom they obtained their drugs. The amendment states:

> "Upon request of a law enforcement agency, emergency medical service personnel and any firefighter or volunteer firefighter acting within the course of the firefighting profession shall disclose the name and address, if known, of an individual to whom the emergency medical services personnel, firefighter, or volunteer firefighter administered naloxone due to an actual or suspected drug overdose, unless the emergency medical services personnel, firefighter, or volunteer firefighter reasonably believes that the law enforcement agency making the request does not have jurisdiction over the place where the naloxone was administered."

The AMCNO voiced concern that this amendment appears to contradict the efforts of HB 249, Ohio's 911 Good Samaritan legislation. HB 249 is a bill that aims to empower overdose witnesses to save a life in the event of an overdose by providing limited protections from arrest (to the victim of the overdose and the person who calls 911 for help) for low-level drug offenses and thereby helping to remove the fear of calling 911 in a medical emergency. According to a recent survey of high-risk opioid users in Ohio, only 58% of individuals called 911 the last time they witnessed an overdose.

The AMCNO was concerned that if this bill were to pass with this amendment, the percentage of those willing to call 911 would only decrease and, therefore, unintentionally contribute to the growing rate of overdose fatalities in our state by reinforcing the fear of calling 911 in the event of an overdose. The AMCNO and several other medical associations sent a letter to Sen. Seitz asking him to consider removing the amendment in HB 110.

In response to the associations, Sen. Seitz indicated that he did not agree that the amendment was contradictory to HB 249; and that he is now working with the sponsor of HB 249 – Rep. Robert Sprague (R-Findlay) in an effort to amend HB 110 to include the provisions of HB 249 in the legislation. Sen. Seitz is also working on making changes to the amendment that would clarify that the notification to law enforcement is for "investigation and referral to treatment." The latest draft version of HB 110 would amend HB 110 to include HB 249, however as written includes changes that could deter an overdose victim or a witness of an overdose from calling 911. Specifically the latest draft version of the bill includes what is being called a "3 strikes" provision, which states that the protections in the bill would not apply to any person who previously has been granted one or more immunities – so if they are involved in an overdose situation a third time the protections outlined under the bill will not be applicable. At press time, the AMCNO was working with several medical associations and others in the community to determine how to best address these issues.

Step Therapy Legislation Introduced – AMCNO Participates in Advocacy Day to Show Support

In February, SB 243 and HB 443 were introduced in the Ohio legislature. SB 243 and HB 443 seek to minimize barriers to treatment by improving the step therapy process. SB 243 is sponsored by Senator Peggy Lehner (R-Kettering) and Senator Charleta Tavares (D-Columbus). HB 443 is sponsored by Representative Terry Johnson (R-McDermot) and Representative Nickie Antonio (D-Lakewood).

Step therapy is a tool insurers use to limit how much they spend covering patients' medications. Under step therapy, a patient must try one or more drugs chosen by their insurer—usually based on financial, not medical, considerations—before coverage is granted for the drug prescribed by the patient's healthcare provider. Patients may be required to try one or more alternative prescription drugs that are of lower cost to the insurer, but may not be the best therapy for some patients.

SB 243 and HB 443 seek to improve the step therapy process by:

- Requiring that an insurer's process for requesting a step therapy override is transparent and available to the provider and patient.
- Allowing automatic exceptions to step therapy requirements when:
  - The required prescription drug is contraindicated or will likely cause an adverse reaction;
  - The required prescription drug is expected to be ineffective;
  - The patient has previously tried the required drug or a drug in the same pharmacologic class and the drug was ineffective or caused an adverse event;
  - The required prescription drug is not in the best interests of the patient based on medical appropriateness; or
  - The patient is stable on a prescription drug for the medical condition under consideration.
- Ensuring that step therapy programs are based on clinical guidelines developed by independent experts.

The AMCNO strongly supports both SB 243 and HB 443, and the AMCNO staff was on hand to lend support to the bills by providing information to key legislators during a Step Therapy Advocacy Day event conducted on the day the two bills were introduced.

SMBO – One-Bite Update

The AMCNO has been working with a coalition of medical associations known as the "MAC" to address the State Medical Board of Ohio (SMBO) plans to change the one-bite rule in Ohio. Over the last few months, several members of the MAC have been meeting with several legislators along with representatives from the SMBO to discuss how to best address this issue. The SMBO has continued to express concern about abdication of board authority. The MAC continues to point out that the requirement to report to the SMBO for determination of one-bite eligibility is required; any voluntary participation and the one-bite program will cease.

As a result of these discussions with legislators and the MAC, the SMBO has sent a memorandum to the medical organizations indicating that they would withdraw legislation that would create and implement the First Occurrence Recovery Program (FOR Program) and to maintain the one-bite rule as-is for the time being. They have also decided to convene a working group which will consist of all of the medical associations involved in the MAC, including the AMCNO, as well as treatment providers and SMBO representatives to discuss how to improve the one-bite program and to explore enhancements for treatment provider standards. The first meeting of this group is scheduled to take place in late March. We are hopeful that we will be able to come to collective agreement surrounding the one-bite rule that will improve the process and encourage physicians to seek out help under a confidential system.

CVS Health to Offer Naloxone in Ohio Stores

CVS Health is making the heroin-countering naloxone available at all of its Ohio stores beginning later this year. The overdose antidote will be in stock beginning in March, and will not require a prescription to purchase.

Naloxone is a fast-acting medication that can reverse the effects of opioids like heroin by reversing the depression of the central nervous system and respiratory system. Able to be injected or inhaled, the drug—under the brand name Narcan—has not before been available in stores in the state.

The move adds Ohio to the more than one dozen states in which the drug is available without a prescription—a list that already includes Arkansas, California, Indiana, Minnesota, Mississippi, Montana, New Jersey, New York, North Dakota, Pennsylvania, Tennessee, Utah and Wisconsin.

At press time, Kroger had just announced that they are planning a similar move in their stores. The AMCNO has strongly supported legislative changes in Ohio to make naloxone more readily available and we applaud CVS and Kroger for this decision. ■

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AMCNO President Dr. Levy Participates in Program to Discuss Hospital Consolidations *(Continued from page 1)*

Ryan shared his views on how mergers improve technology structures. Smaller hospitals have a more difficult time accessing the capital needed for new technology, he said. Larger hospitals do, however, have the finances and capabilities for the technology, which when brought to the smaller hospitals, allow the smaller hospital to better manage the health of the populations they serve. They join the infrastructure—the medical records and billing process—of the larger hospital.

Silvers said that there has been a 50-year trend of hospital changes. It started in the 1970s and '80s, then moved into a stage of rationalizations, moving costs down. Now the third part has become a question of whether you can provide health care better than you did before and with better outcomes, he said. And, if you can't, you will be penalized for it. Silvers said he sees consolidations as a positive for healthcare systems and patients: "Outcomes are much better, and they improve population health."

He added that in terms of costs and market power, however, the benefits are debatable, saying that larger systems have more clout and can do better financially. But, costs may increase for consumers because less competition drives up costs.

McIntyre said that it seems there are benefits to consolidations, though, especially when it comes to larger hospitals being able to purchase new technology that individual practices may not be able to afford.

Dr. Levy agreed, saying that the cost of running a practice has become "astronomical," referencing electronic health records, in-office services (such as equipment and new technology, especially for certain specialties), and a decrease in physician reimbursements, particularly for Medicare. These are the things that "drive physicians to look for consolidations, look for one of the big systems to join," he said.

Ryan added that physicians also have to think about the process of being paid. "The billing and collection process is expensive," he said. "When a physician goes to work for a hospital, they no longer have to worry about that piece of the operation… I've talked to independent doctors and they say they spend as much time trying to get paid for their services as they do delivering their services."

Dr. Levy said that, alternately, physicians are concerned about the loss of autonomy. "As physicians, that's a lot of what drives us and what motivates us, the autonomy, and that's what's being lost here," he said.

Silvers pointed out that policy changes (and not just economics) are helping drive mergers and acquisitions. We are also moving into a period of change concerning the physician's fee schedule, which he said will change in two ways: How physicians manage populations—what is the total cost per person, per year—and by gauging the quality of care.

Gaynor discussed the work he has done studying mergers and what they mean for patients in terms of costs. He said that as in other economic sectors, when competition decreases, prices go up for consumers, in one way or another, despite insurance companies making changes and developing their own market power.

McIntyre asked the panelists for their views on the future of health care and consolidations in 2016 and beyond. One panelist said mergers will continue to take place; although, in Ohio, many have already occurred. And, cities will likely have one or two large health systems, as we're seeing in many cities now.

During the program, the panelists also addressed the questions and concerns of listeners who called in.

To hear the entire program, visit www.ideastream.org. ■

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UNCOMPROMISING PROTECTION

AMCNO is On Hand for the GCOAT's Release of New Acute Pain Prescribing Guidelines

Recently, the Governor's Cabinet Opiate Action Team (GCOAT) released *Guidelines for the Management of Acute Pain Outside of Emergency Departments* for outpatient management of acute pain expected to resolve within 12 weeks. The guidelines were drafted by the GCOAT, which included staff and physician representatives from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and staff from the AMCNO was on hand at the news conference when the official statement was released.

Representatives from the Kasich administration and the Ohio Department of Health discuss the GCOAT acute pain prescribing guidelines with the media at the press conference.

The guidelines recommend non-opioid treatment options when possible and limiting the amount of opioids used to treat acute pain where appropriate. They expand upon Ohio's prescribing guidelines for emergency departments and acute-care facilities, which were released in 2012 and 2013. As with those previous guidelines, these new guidelines are intended to supplement—not replace—clinical judgment. All three of these guideline sets were developed in conjunction with clinical professional associations and providers.

In recent years, both the number of opioid doses dispensed to Ohio patients and the number of "doctor shoppers" have decreased, according to data from the Ohio Automated Rx Reporting System (OARRS). But, there is more work to do. Prescription opioids remain a significant contributor to unintentional drug overdose deaths in Ohio, and the number of overdose deaths increased year-to-year from 2012 through 2014.

"Too many families are being torn apart by drugs and that is why we have been so proactive in exploring new ways to prevent Ohioans from becoming addicted to prescription opioids," said Gov. John Kasich. "Building upon prescribing guidelines we established for emergency departments and chronic pain, these new protocols for treating short-term pain will strengthen our efforts to fight abuse and ultimately save lives."

The AMCNO also worked with other healthcare associations and state leaders to previously establish guidelines for treating pain in emergency rooms and for treating chronic pain.

Visit www.opioidprescribing.ohio.gov to review the new guidelines as well as the others that were previously released. Also on the website are prescriber tools and resources, including a letter to give patients that explains a safer approach to treating their acute pain following these guidelines. The new guidelines are also included in this issue (see pages 8 and 9). ■

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Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments

Preface: This guideline provides a general approach to the outpatient management of acute pain. It is not intended to take the place of clinician judgement, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient. This guideline is the result of the work from the Governor's Cabinet Opiate Action Team (GCOAT) and the workgroup on Opioids and Other Controlled Substances (OOCS).

Introduction

In 2014, 2,482 individuals in Ohio died from an unintentional opioid-related overdose – more than a four-fold increase in 10 years[1]. Unintentional opioid overdose has become one of the leading causes of injury-related death in Ohio over the past decade. To respond to this challenge, public health and health care leaders have committed to helping healthcare providers better serve their patients with pain, while reducing the potential for overdose and death. As part of the Governor's Cabinet Opiate Action Team (GCOAT), the workgroup on Opioids and Other Controlled Substances (OOCS) was charged with developing guidelines for the safe, appropriate and effective prescribing of self-administered medications for pain. The two previously released guidelines are:

- Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances Prescribing Guidelines [Released 2012; Revised 2014]
- Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain 80mg of a Morphine Equivalent Dose (MED) "Trigger Point" [Released 2013]

Purpose

This third guideline is focused on the management of acute pain and the prescribing of self-administered medications for acute pain, delineating a standardized process that includes **key checkpoints** for the clinician to pause and take additional factors into consideration.

Definition of Acute Pain

For this guideline, acute pain is defined as pain that normally fades with healing, is related to tissue damage and significantly alters a patient's typical function. Acute pain is expected to resolve within days to weeks; pain present at 12 weeks is considered chronic and should be treated accordingly. This guideline may not apply to acute pain resulting from exacerbations of underlying chronic conditions.

Assessment and Diagnosis of Patient Presenting with Pain

For assessing patients presenting with acute pain, in addition to a proper medical history and physical exam, initial considerations should include:

- Location, intensity and severity of the pain and associated symptoms
- Quality of pain e.g. somatic (sharp or stabbing), visceral (ache or pressure) and neuropathic pain (burning, tingling or radiating)[2]
- Psychological factors, including personal and/or family history of substance use disorder

A specific diagnosis should be made, when appropriate, to facilitate the use of an evidence-based approach to treatment.

Develop a Plan

Upon determining the symptoms fit the definition of acute pain, both the provider and patient should discuss the risks/benefits of both pharmacologic and non-pharmacologic therapy. The provider should educate and develop a treatment plan together with the patient that includes[3]:

- Measureable goals for the reduction of pain
- Use of both non-pharmacologic and pharmacologic therapies, with a clear path for progression of treatment
- Mutually understood expectations for the degree and the duration of the pain during therapy
- **Goal: Improvement of function to baseline or pre-injury status as opposed to complete resolution of pain**

Treatment of Acute Pain

While these guidelines provide a pathway for the management of acute pain, not every patient will need each option and care should be individualized.

Non-Pharmacologic Treatment

Non-pharmacologic therapies should be considered as first-line therapy for acute pain unless the natural history of the cause of pain or clinical judgment warrants a different approach. These therapies often reduce pain with fewer side effects and can be used in combination with non-opioid medications to increase likelihood of success. Examples may include, but are not limited to:

- Ice, heat, positioning, bracing, wrapping, splints, stretching and directed exercise often available through physical therapy
- Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, manipulation, and osteopathic neuromuscular care
- Biofeedback and hypnotherapy

Non-Opioid Pharmacologic Treatment

Non-opioid medications should be used with non-pharmacologic therapy. When initiating pharmacologic therapy, patients should be informed on proper use of medication, importance of maintaining other therapies and expectation for duration and degree of symptom improvement. Treatment options, by the quality of pain, are listed below.

Somatic Pain

- Acetaminophen
- Non-steroidal anti-inflammatory drugs (NSAIDS)
- Corticosteroids

Alternatives include the following: gabapentin/pregabalin, skeletal muscle relaxants, serotonin-norepinephrine reuptake inhibitors, selective serotonin reuptake inhibitors and tricyclic antidepressants.

Visceral Pain

- Acetaminophen
- Non-steroidal anti-inflammatory drugs (NSAIDS)
- Corticosteroids

Alternatives include the following: dicyclomine, skeletal muscle relaxants, serotonin-norepinephrine reuptake inhibitors, topical anesthetics and tricyclic antidepressants.

Neuropathic Pain

- Gabapentin/pregabalin
- Serotonin and norepinephrine reuptake inhibitors
- Tricyclic antidepressants

Alternatives include the following: other antiepileptics, baclofen, bupropion, low-concentration capsaicin, selective serotonin reuptake inhibitors and topical lidocaine.

Opioid Pharmacologic Treatment

In general, reserve opioids for acute pain resulting from severe injuries or medical conditions, surgical procedures, or when alternatives (non-opioid options) are ineffective or contraindicated. Short-term opioid therapy may be preferred as a first line therapy in specific circumstances such as the immediate post-operative period. In most cases, opioids should be used as adjuncts to additional therapies, rather than alone.[4] It is critical that healthcare providers communicate with one another about a patient's care if the patient may be receiving opiate prescriptions from more than one provider to ensure optimum and appropriate pain management. The following are recommendations for the general use of opioids to manage acute pain:

- Appropriate risk screening should be completed (e.g. age, pregnancy, high-risk psychosocial environment, personal or family history of substance use disorder).
- Provide the patient with the least potent opioid to effectively manage pain. A morphine equivalence chart should be used if needed.
- Prescribe the minimum quantity needed with no refills based on each individual patient, rather than a default number of pills.
- Consider checking Ohio Automated Rx Reporting System (OARRS) for all patients who will receive an opiate prescription. (Note: An OARRS report is required for most prescriptions of seven days or more.)
- Avoid long-acting opioids (e.g. methadone, oxycodone ER, fentanyl).
- Use caution with prescribing opioids with patients on medications causing central nervous system depression (e.g. benzodiazepines and sedative hypnotics) or patients known to use alcohol, as combinations can increase the risk of respiratory depression and death.
- Discuss with the patient a planned wean off opioid therapy, concomitant with reduction or resolution of pain.
- Discuss proper secure storage and disposal of unused medication to reduce risks to the patient and others.
- Remind the patient that it is both unsafe and unlawful to give away or sell opioid medication, including unused or leftover medication.

Pain Reevaluation

Key Checkpoint: Reevaluation of patients who receive opioid therapy for acute pain will be considered if opioid therapy will continue beyond 14 days. This reevaluation may be through an office visit or phone call based on the discretion of the provider.

For patients with persisting pain, providers should reevaluate the initial diagnosis and consider the following:

- Pain characteristics (consider using a standardized tool [e.g. Oswestry Disability Index])
- Treatment methods used
- Reason(s) for continued pain
- Additional management options, including consultation with a specialist

Additional Checkpoint:

For patients with pain unresolved after 6 weeks, providers should repeat an assessment and determine whether treatment should be adjusted. Referral to guidelines on chronic pain management may be helpful at this point, although chronic pain is defined as pain persisting for longer than 12 weeks.

References:

1. ODH, Office of Vital Statistics, Analysis by Injury Prevention Program. 2013.
2. Institute for Clinical Systems Improvement. Assessment and management of acute pain. Bloomington (MN): Institute for Clinical Systems Improvement; 2008 Mar. 58p.
3. Massachusetts Medical Society Opioid Therapy and Physician Communication Guidelines. May 21, 2015.
4. Washington State Agency Medical Directors Group. Interagency Guideline on Prescribing Opiates for Pain Washington State Guidance. June 2015.

Terminating Hospital Employment Agreements

Don't Forget About Your Clinical Privileges

By Laura F. Fryan, Esq. and J. Ryan Williams, Esq., Brouse McDowell

What would happen if you resigned from your job tomorrow or were fired? This is an uncomfortable question to consider whether you are currently employed, negotiating an agreement for a new position, or considering a job in the future. However, the answer to this question is important to know in any employment relationship, especially if your employment also includes privileges on the medical staff at a hospital.

It is no secret that hospitals are a major employer of physicians, especially in Northeast Ohio. By entering into an employment relationship with physicians, hospitals assume a greater degree of control over physicians that they would otherwise not have, and most hospitals preserve the traditional medical staff structure and require their employed physicians to also maintain membership and privileges on the medical staff. As such, these physicians assume a dual role as a hospital employee and a member of the hospital's medical staff. This dual role implicates several important issues, including whether the physician has certain rights, which are typically afforded in medical staff peer review actions, in connection with employment termination actions, and the obligation to report employment termination actions to the federal government's National Practitioner Data Bank (NPDB). If you are one of these physicians, your employment agreement with the hospital may not address your rights under the medical staff bylaws in the event that your employment is terminated or you resign. Furthermore, depending on the nature of your termination or resignation, the hospital may have to make a report to the NPDB in certain circumstances when you leave.

Issues arise in this context because there are many differences (legal and practical) between termination of employment and termination of medical staff privileges. Unless otherwise addressed in a physician's employment agreement or the medical staff bylaws, termination of a physician's employment does not automatically terminate the physician's clinical privileges. In that case, the hospital would have to institute proceedings under the medical staff bylaws to terminate the physician's privileges after the physician's employment is terminated. For most physicians employed by a hospital, however, the physician's employment agreement with the hospital provides that termination of employment, whether for cause or without cause, may be automatic grounds for termination of staff privileges. In such a case, any due process rights under the medical staff bylaws as they relate to staff privileges are waived, and the physician has no rights under the fair hearing plan or other appeal mechanisms that may be available to other members of the medical staff, such as non-employed, community physicians.

Alternatively, a physician's employment agreement with the hospital may contractually require the physician to resign from the hospital's medical staff upon termination of the employment relationship. Some employment agreements may even prohibit the physician from re-applying for medical staff privileges at that hospital during a specified period of time.

As you can see, an important issue to consider is whether your employment agreement with the hospital is subject to the terms of the hospital's medical staff bylaws. Language in your employment agreement may state that in the event of a conflict between the employment agreement and the medical staff bylaws, the medical staff bylaws control. Or, certain provisions in your employment agreement may state that its terms are subject to the medical staff bylaws. When entering into an employment agreement with a hospital, the medical staff bylaws should be carefully considered in conjunction with the employment agreement so that you understand how your employment is affected by the medical staff bylaws.

You may be thinking that if your employment agreement with the hospital provides for termination of your clinical privileges, there are no additional considerations. Be cautious, though, because if you are the subject of a professional review action when your employment terminates, or if the hospital performs a professional review of your privileges in conjunction with or as a result of termination of employment, the hospital may be required to make a report to the NPDB. Hospitals must report adverse clinical privileges actions to the NPDB that meet NPDB reporting criteria—that is, any professional review action that adversely affects the clinical privileges of a physician for a period of more than thirty days or the acceptance of the surrender of clinical privileges, or any restriction of such privileges by a physician, (1) while the physician is under investigation by a hospital relating to possible incompetence or improper professional conduct, or (2) in return for not conducting such an investigation or proceeding. A professional review activity means an activity of a hospital with respect to a physician: (1) to determine whether the physician may have clinical privileges at the hospital; (2) to determine the scope or conditions of such privileges; or (3) to change or modify such privileges. Adverse clinical privileges actions must be reported when based on a physician's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

The most recent version of the NPDB Guidebook maintains the distinction between professional review under a hospital's medical staff bylaws and employment termination procedures. As long as a physician is not subject to a professional review action, the termination of a physician's clinical privileges is not a reportable event. The Guidebook states that it does not matter that the employment termination, which was a result of the hospital's employment termination process, automatically resulted in the end of the practitioner's clinical privileges. However, if the hospital utilizes the professional review process and revokes the physician's privileges as a result of the review, the professional review action is reportable, even if the action started as an employment termination. Also, as noted above, hospitals are

also required to make a report to the NPBD if a physician voluntarily surrenders his or her clinical privileges in return for not conducting an investigation or proceeding. This means that if a physician terminates his or her employment during a professional review action and, pursuant to the physician's contract, his or her clinical privileges terminate, the hospital has a duty to make a report to the NPDB.

In some cases, hospitals still make a report to the NPDB regarding the events surrounding termination of a physician's employment. In litigation that has spawned from such reports, courts have upheld a hospital's right to report the circumstances surrounding a physician's termination to the NPDB even where the physician's employment agreement afforded the physician no right to any due process.

When planning to exit an employment relationship with a hospital, make sure that you are not the subject of a professional review action at that time. If you terminate your employment agreement pending any professional review action and your clinical privileges are also terminated accordingly, even administratively or by operation of your employment agreement the hospital is required to make a report to the NPDB. When negotiating or renewing your employment agreement, consider requesting procedural rights to challenge an action that may generate an NPDB report. Review your employment agreement and the hospital's medical staff bylaws to ensure that those rights are available to you if the hospital determines that an NPDB report must be made. ■

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AMCNO Files Amicus Brief in Statute of Repose Issue Before the Ohio Supreme Court

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

By Bret C. Perry, Esq., Shareholder with Bonezzi Switzer Polito & Hupp Co. L.P.A.

The Ohio Supreme Court will soon consider whether Ohio's statute of repose (R.C. 2305.113(C)) applies when the occurrence of the act or omission constituting the alleged medical malpractice takes place more than four years prior to the filing of the lawsuit, regardless of whether a cause of action has vested.

R.C. 2305.113(C) was enacted to protect physicians and other medical practitioners from stale lawsuits, expressly precluding lawsuits from being commenced more than four (4) years after the alleged act of negligence. The purpose of the statute of repose was to provide medical providers certainty with respect to the time within which a claim can be brought and after which they may be free from litigation. However, the Eighth District Court of Appeals in the matter of *Antoon v. Cleveland Clinic Foundation,* 8th App. No. 101373, 2015-Ohio-421, has threatened this legislation by drastically curtailing the application and impact of the statute of repose in a manner fundamentally inconsistent with the express language of R.C. 2305.113(C).

In *Antoon,* Plaintiff filed his medical malpractice action on November 13, 2013. Plaintiff alleged multiple causes of action arising from medical care provided on January 8, 2008. Based on the nearly six-year time lapse between the date of the alleged medical negligence and the filing of the lawsuit, Defendants moved to dismiss the alleged claims based on the failure to file the action within the four years required by Ohio's statute of repose and the failure to comply with Ohio's one-year malpractice statute of limitations. The trial court granted Defendants' Motion, finding that the claims were time-barred by Ohio's four-year statute of repose pursuant to R.C. 2305.113(C).

On appeal to the Eighth District Court of Appeals, the trial court's dismissal was reversed, finding that once a cause of action vests, or once a plaintiff becomes aware of his or her potential cause of action, the statute of repose is no longer relevant to a determination of the timeliness of a complaint. The Eighth District concluded that the statute of repose has no application whenever a claim or cause of action vests within the four-year period provided by R.C. 2305.113(C). In so holding, the Eighth District's ruling has cast a shadow of uncertainty regarding the application of R.C. 2305.113(C). Further, if the Eighth District's decision remained unchallenged, the purpose of R.C. 2305.113(C) would be rendered moot because the decision has obfuscated the mandate to preclude cases filed more than four years after the date of the alleged medical malpractice, essentially requiring Ohio physicians to endure the burden and costs associated with discovery necessary to sufficiently support a statute of limitations argument.

Fortunately, the Ohio Supreme Court accepted jurisdiction of the *Antoon* matter and will now consider the decision of the Eighth District of Appeals. Bret C. Perry, Esq. and Jason A. Paskan, Esq. filed an *Amicus curiae* (literally "Friend of the Court") on behalf of AMCNO with the Ohio Supreme Court urging reversal of the Eighth District Court of Appeals decision. An *Amicus* filing generally allows individuals and entities who are not parties to a case, but who have an interest in the outcome, to have an opportunity to be heard.

The *Amicus* brief on behalf of AMCNO encourages the Ohio Supreme Court to find that R.C. 2305.113(C) applies to any cause of action when the occurrence of the act or omission constituting the alleged medical malpractice takes place more than four years prior to the filing of the lawsuit, regardless of whether a cause of action has vested.

In the *Antoon* matter, the AMCNO contends that Ohio's statute of repose was adopted for the purpose of providing certainty to physicians, as well as other medical practitioners, by procedurally barring the filing and/or litigation of stale lawsuits after four years from the date of the alleged medical malpractice. The AMCNO also argues that the statute of repose serves the critical public policy purpose of prohibiting the litigating of medical malpractice actions after such time because documents are no longer retained and memories are no longer fresh.

R.C. 2305.113(C) states:

(1) No action upon a medical, dental, optometric, or chiropractic claim shall be commenced more than four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim.

(2) If an action upon a medical, dental, optometric, or chiropractic claim is not commenced within four years after the occurrence of the act or omission constituting the alleged basis of the medical, dental, optometric, or chiropractic claim, then, any action upon that claim is barred.

Under a plain reading of the statute, the filing of a medical malpractice action, more than four years after the occurrence of the act or omission which forms the basis of the alleged negligence, is prohibited because "No action… shall be commenced more than four years after the occurrence, otherwise it is time-barred. R.C. 2305.113(C) does not contain

AMCNO OHIO SUPREME COURT ACTIVITIES

language that restricts its application only to those instances where an injured party has not yet realized that he or she may have been injured by an act of medical negligence, nor is there a limitation placed by the statute to apply only to original filings of a case.

Notwithstanding, the Eighth District interpreted the statute to apply only under such limited circumstances, severely undercutting the plausible scenarios under which R.C. 2305.113(C) would be effective in limiting the commencement of stale lawsuits. If the Eighth District's holding is to serve as the new standard rule regarding the applicability of R.C. 2305.113(C), the statute of repose will never effectively preclude any cause of action from being brought because a right to remedy is "vested" once a plaintiff becomes aware of his or her potential cause of action, thereby limiting the timeliness of the filing to a statute of limitations analysis. The effect of this interpretation severely restricts and diminishes the statute of repose to the point of rendering the subsection meaningless.

Moreover, the AMCNO argued that the Eighth District's decision is inconsistent with prior holdings from the Ohio Supreme Court which previously identified several important policy considerations underlying R.C.2305.113(C), such as a defendant being entitled to a reasonable time after which he or she can be assured that a defense will not have to be mounted for actions occurring years before. Further, the Ohio Supreme Court has found that the core purpose underlying a statute of repose is to give medical practitioners a sense of certainty as to the time within which a claim can be brought against them, and a further confidence that practitioners may be free from the fear of litigation after extended periods of time.

The statute of repose is critically important to physicians, hospitals, and other medical practitioners across Ohio because it was intended to place a hard and fast expiration date on a potential cause of action. Concerns regarding medical malpractice insurance also justify statutes of repose. For example, a practitioner may retire and thus no longer carry, or need, professional liability insurance. Further, a practitioner's insurer may become insolvent over the span of several years. Additionally, institutional medical providers may also have closed since the time of the actionable incident. The Eighth District's holding essentially acts to artificially restrict the application of R.C. 2305.113(C), and, in so doing, has frustrated this important Ohio public policy.

In the matter of *Antoon,* and many others where the four-year deadline imposed by R.C. 2305.113(C) would apply, the complaint will not conclusively allow for an analysis on the statute of limitations issue, resulting in a denial of the motion, or the need to convert the motion to dismiss into a motion for summary judgment. In turn, this subjects what should be a simple procedural question into a complex issue requiring additional discovery, the time and costs associated therewith, and the prolonged uncertainty that litigation brings. By restricting the statute of repose to only those situations where vesting has not occurred, the Eighth District has drastically constrained the application of the statute of repose and has created a situation where it will have very little meaningful impact. The public policy reasons will not be served by limiting the application of R.C. 2305.113(C) to those situations suggested by the Eighth District because the continued litigation of matters filed beyond the four-year statute of repose, rather than an early dismissal, would require the exhaustion of time and resources that R.C. 2305.113(C) was enacted to prevent.

The AMCNO as well as the Ohio Hospital Association, Ohio Osteopathic Association, and Ohio State Medical Association have filed *Amicus* briefs in this case noting the potential negative impact on its members if left undisturbed. The decision of the Eighth District, if not reversed, will have a negative impact on healthcare practitioners throughout Ohio resulting in the revival of otherwise stale claims for medical malpractice. ■

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Board Convenes at Cleveland Museum of Natural History to Learn about the Centennial Project

The AMCNO Board of Directors "went on the road" in January and conducted their meeting at the Cleveland Museum of Natural History. Dr. Evalyn Gates, Executive Director of the museum, provided the AMCNO board members with an overview of the museum's Centennial Project. AMCNO board members Drs. Fred Jorgensen and James Coviello are currently representing the AMCNO on the museum's health advisory committee and had asked that the AMCNO Board be afforded the opportunity to learn more about this important community project.

Dr. Gates outlined how the museum would be transformed into a place where not only children but adults would come to learn and get engaged with the various interactive exhibits. Dr. Gates noted that the museum is building for the future of our community. By renovating and modernizing the 60-year-old facility, they will expand and enhance their signature science education programs, incorporate their state-of-the-art research labs into the visitor experience, and properly care for and curate their collections. She also noted that a key part of the project is to ensure that museum visitors will have an opportunity to interact with real science.

She noted that this is a five-year project that will be done in three phases with the goal to complete the entire project in time for the museum's Centennial in 2020. The first phase began in March 2015 and includes a new Perkins Wildlife Center & Woods Garden and a new parking garage. This phase will be completed by spring 2016.

Phase 2 is targeted for late 2016 and will include a new exhibit wing and research and collections areas as well as an expanded inner courtyard. The final phase will include a new auditorium, gallery and Discovery Center.

The new exhibits wing will house innovative and interactive exhibit galleries, which will include a Living Planet Gallery, Astronomy and Cosmology Gallery, Origins of Life Gallery, the Parker Hannifin Dinosaur Gallery, the World of Mammals Gallery, the Human Research and Human Health Galleries, a Naturalist Center Gallery and an Art and Nature Gallery.

The plan is to ensure that the museum can provide science education classes and programming and maintain the important scientific research that happens at the museum on a regular basis. The museum will showcase their science by bringing curators, scientists, collections and labs out of the basement and integrate them into the visitor experience. Classrooms and educational spaces will be incorporated into the galleries—greatly enhancing the learning experience.

The expanded museum will house a unique integration of galleries, collections, labs and research that showcases their world-renowned assets and discoveries and creates an interactive learning experience for visitors.

There is also a plan to change the traffic pattern outside of the museum to make it easier for visitors to find where to park and where to enter the facility. Dr. Gates also noted that the huge Viktor Schreckengost sculptures of a mammoth and mastodon that once adorned the Pacchyderm Building at the Cleveland Metroparks Zoo will soon start a new life on the grounds of the museum. Dr. Gates stated that the sculptures would function as a showpiece at one of the major entry points to University Circle.

Dr. Evalyn Gates addresses the AMCNO Board of Directors during their recent meeting at the CMNH.

The $150 million Centennial Campaign will enable the museum to expand and transform every part of its campus for their Centennial in 2020.

Editor's note: *The AMCNO and our physician leadership were integrally involved in establishing the original health museum in Northeast Ohio in 1936. In 2007, the health museum was merged into the CMNH and we are pleased to continue to be involved with their important work through the health advisory committee.*

AMCNO Board of Directors Adopts Policies Regarding Mandatory Continuing Medical Education (CME)

There has been extensive discussion at the AMCNO Board of Directors about the possibility that either the legislature or the State Medical Board of Ohio (SMBO) will require mandatory continuing medical education (CME) for opioid prescribing or for pain management in the future.

The AMCNO recognizes that to require mandatory CME requirements is not always necessary or helpful; however, we also recognize that certain societal problems could be impacted by appropriate training and education. In general the AMCNO Board was in favor of mandatory CME for prescribing narcotics but not for pain management since this is a much broader topic. Based upon their discussions, the AMCNO Board of Directors adopted the following resolution regarding CME courses for narcotic prescribing:

WHEREAS, Ohio is facing a critical public health issue related to prescription drug abuse and physicians in Northern Ohio take their role in helping fight this problem very seriously; and

WHEREAS, It is a possibility that there may be requirements in the future for physicians in Ohio to obtain mandatory content-specific CME hours on topics related to appropriate opioid prescribing in order to retain their license in the State of Ohio; and

WHEREAS, The AMCNO believes that there is a reasonable expectation that CME courses on the topic of appropriate narcotic prescribing could be effective in improving patient care and increasing patient safety in the physicians' practice, therefore be it

RESOLVED, That the AMCNO agrees in principle to work with the State Medical Board of Ohio and other medical organizations and associations as necessary on the development of content-specific CME courses to address appropriate narcotic prescribing for physicians.

After the AMCNO Board adopted this resolution, another issue arose in the legislature that would require mandatory CME for cultural competency (SB 33). The AMCNO signed onto a letter to the Senate Health and Human Services Committee along with numerous other medical associations outlining our concerns with this bill.

The AMCNO Board reviewed this issue and expressed concern that this was just one of many attempts that will be made by the legislature or the SMBO to start mandating other content-specific CME requirements for physicians. The AMCNO agrees that physicians should engage in content-specific CME when CME intervention is appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians' practice, as was the instance when the AMCNO agreed in principle to work with other medical associations and the SMBO on content-specific CME for narcotic prescribing. However, the AMCNO Board in general does not support content-specific CME mandates for licensure or mandates through the legislature.

Based on their discussions the AMCNO Board of Directors adopted the following resolution regarding content-specific education activities:

WHEREAS, The AMCNO believes that physicians should be able to determine their initial and continuing education needs based upon their individual areas of expertise, practice type or specialty and the clinical needs of their patient population; and

WHEREAS, The AMCNO is of the opinion that mandated content-specific continuing education intrudes on the profession's responsibility to determine appropriate educational requirements, therefore be it

RESOLVED, That the AMCNO oppose licensure or legislative initiatives that include mandatory content-specific CME requirements and be it further

RESOLVED, That the AMCNO recommend that physicians engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physician's practice.

Editor's note: *The AMCNO Board of Directors also approved a policy statement regarding medical marijuana. For more information on this policy statement,* *see page 2 in this issue.*

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

Solving the Third-Party Payer Puzzle

May 4, 2016

Location: AMCNO Executive Offices, Park Center Plaza I, 6100 Oak Tree Blvd., Independence, OH 44131

This is your opportunity to hear representatives from private payers, Medicare and Medicaid discuss their latest rule changes and claims submission issues that will impact your practice.

AGENDA
Wednesday, May 4, 2016

7:30 a.m. – 8 a.m. ***Registration and breakfast***

8 a.m. – 8:30 a.m. ***Medical Mutual Of Ohio***
2016 Updates

8:30 a.m. – 9:00 a.m. ***Anthem Blue Cross Blue Shield***
2016 updates including but not limited to:
- New Medicare Advantage precert tool
- Interactive Care Review tool (ICR)
- OrthoNet, AIM and ICD-10
- Availity

9:30 a.m. – 9:45 a.m. ***Break***

9:45 a.m. – 11:30 a.m. ***Ohio Medicare/CGS***
Information regarding medical record review contractors
- Comprehensive Error Rate Contractor (CERT)
- Recovery Auditor (RA)
- CGS Medical Review (MR)

Discuss new and ongoing Medicare initiatives

11:30 a.m. – Noon ***Lunch***

11:45 a.m. – 1:30 p.m. ***Ohio Medicaid***
- MyCare Ohio
- Eligibility
- ICD-10
- Policy updates
- Physician credentialing tips and timelines
- Budget initiatives

1:30 p.m. - 1:45 p.m. ***Break***

1:45 p.m. - 2:15 p.m. ***Buckeye Health Plan***
- MyCare Ohio
- Eligibility
- Prior Auth and operational updates
- HEDIS – Quality

2:15 p.m. - 2:45 p.m.
UnitedHealthcare Community Plan of Ohio
- UnitedHealthcare Connected for MyCare Ohio
- Ohio Dual Special Needs Plan

2:45 p.m. - 3:15 p.m. ***CareSource***
Speaker confirmed, Topics TBD

3:15 p.m. - 3:45 p.m. ***Paramount***
- Latest HEDIS results
- Claims Submission
- ICD-10 and Secondary Claims
- Website Resources

3:45 p.m. - 4:15 p.m. ***Molina***
Speaker invited, Topics TBD

Registration Fees
AMCNO Member: $50, AMCNO Member Staff Person: $50
Non-member: $100

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**Payment also accepted day of seminar at registration.

AMCNO Updated Community Resource Guide Now Available

As a member of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), you have access to valuable and informative materials—one of which is the Community Resources Guide. It has been updated recently and is available on our website www.amcno.org.

This listing provides a wealth of knowledge that you can share with your patients when they need assistance within their communities. It features contact information for numerous organizations and healthcare-related groups in the Northeast Ohio region, covering services from practically A to Z (Adoption to Women's Health).

Located right at the top of the list are important numbers to know, including those for the Center for Health Affairs, Cleveland Department of Public Health, Cuyahoga County Board of Health, as well as those for the Greater Cleveland Foodbank, and other healthcare-related organizations.

In addition, the Cleveland chapters of national organizations are featured, such as the American Heart Association, Red Cross and United Way. Also included are resources that may not be commonly found or published in local resource listings, such as Dogs for the Deaf, Parenting Help Lines/Classes, and The Stuttering Foundation.

Some of the AMCNO's services are also listed in the guide, including the Pollen Line and Physician Referral line.

Take a moment to review the Community Resource Guide. It can be a valuable resource for you, your office staff and your patients. ■

SAVE THE DATE

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

invites you to attend our

2016 Annual Meeting

Friday, April 15, 2016

Wyndham Hotel at Playhouse Square
1260 Euclid Ave, Cleveland, OH 44115
6 p.m. Reception • 7 p.m. Dinner • Black Tie Optional

Presentation of 50 Year Awardees and Academy of Medicine Education Foundation (AMEF) Scholarships to medical students from Case Western Reserve University School of Medicine, Cleveland Clinic Lerner College of Medicine, Northeast Ohio Medical University and the Ohio University College of Medicine

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Kevin T. Geraci, MD

CLINICIAN OF THE YEAR
James K. Stoller, MD

OUTSTANDING SERVICE
Robert W. Hostoffer, Jr., DO

HONORARY MEMBERSHIP
William T. Ryan

SPECIAL RECOGNITION
Michael K. McIntyre

PRESIDENTIAL CITATION
Martin T. Galvin, Esq.

Please join us in congratulating our medical scholarship recipients and awardees on April 15, 2016

AMCNO Pollen Counts Kick Off Allergy Season

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