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INSIDE
THIS ISSUE

Board Activities
Pages 3, 4 & 5

Legislative Update
Pages 6 & 7

Legal Issues
Pages 10, 11 & 12

Practice
Management
Pages 15, 16 & 17

Community
Outreach
Pages 18 & 19

Health IT Could Succeed Through Regional Collaboration

David J. Brailer, MD, PhD, addressed a gathering of area health care professionals recently on the national move toward widespread health information technology, and the challenges in meeting demand for improving quality and efficiency along the way. The March 24th event also brought to light the progress to date of Northeast Ohio's own regional efforts, known as the NEO RHIO (see story p. 8).

As the first National Health Information Technology Coordinator, Dr. Brailer began by recalling when he met with the domestic policy council staff at the White House and, after sharing his ideas on the subject, found himself in the Oval Office to have the same discussion with the President himself. "It was clear we lacked a functioning market in health care — patients could not choose where to get treatment or which physicians they could see," he said. "In addition, physicians were facing liability risks that could not be addressed. Given the way the health care system is organized — to change the level of use of life-saving tools, to present errors and enhance research — you will have to change the fundamentals of the industry."



David Brailer, MD discusses the challenges and rewards of a national health information network.

He went on that while we have all read about patient-centered care — increased efficiency, compliance issues, and the use of evidence-based medicine, etc., we lack the vision for where to go

(Continued on page 9)

AMC/NOMA Weighs In on DTC Advertising
and its Impact on Patients

A recent local radio news program featured President **George E. Kikano, MD**, providing a practicing physician's perspective on the increasing prevalence of direct-to-consumer (DTC) advertising of brand-name prescription medications and the impact such is having on the physician-patient relationship. Proponents of the burgeoning incidence of DTC ads say this sort of

marketing educates consumers, while its critics claim it encourages people to demand medicines from their doctors that may not be the best choice for them. During the interview on WCPN's 90.3 at 9 morning news program March 22, Dr. Kikano's views, expressed on behalf of The Academy of Medicine Cleveland/Northern Ohio Medical Association's membership, were emphasized by the other guests as well — a Dartmouth College professor and a bioethicist from the Cleveland Clinic. All seemed to agree on the facts that economics play an overbearing role in the issue, considering the many so-called "blockbuster" drugs that have grossed billions in profits largely based on consumer-driven demand for them and the fact that most drug companies' spending trends are disproportionately focused

(Continued on page 18)

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AMC/NOMA Board Takes Action on Ohio State Medical Board (OSMB) Proposed Rules

In recent months, the Academy of Medicine Cleveland/Northern Ohio Medical Association (AMC/NOMA) received notification from the Ohio State Medical Board (OSMB) that the Board is considering rules to address sexual misconduct by physicians and to clarify the procedures for terminating a patient/physician relationship. The OSMB has just begun the rule promulgation process and the AMC/NOMA, along with other organizations has been asked to comment on the content of the rules. Our first letter dated March 3 deconstructed much of the verbiage contained in the proposal, including such items as “key third party” vs. “patient,” imprecise terms such as a 36-month termination rule and the use of the term “exploitation” in reference to patients, as well as the narrow definitions of termination rule time lines. More substantive were the questions regarding why, in fact, the OSMB needed to implement sexual misconduct rules over the suggestion of simply adopting AMA Ethical Opinions 8.14 and 8.145 — which wholly address the issue and have the force of law in Ohio. “It is our opinion that this entire rule reads like a criminal law statute — which we believe is a marked departure from traditional ethical norms” the letter summarized.

With regard to the termination of the patient/physician relationship rules, the AMC/NOMA asked the Board why there was even a perceived need to place this into a rule that has a force of law. It would seem that the AMA Opinion on this matter should be sufficient. The termination rules clearly would create a situation where a physician could be responsible for the care of a patient for up to 30 days after terminating their care. The AMC/NOMA noted “we could not help but wonder why, except for the ethical obligations to provide continuing care when a case has been undertaken, that physicians should be saddled with a patient like this?”

To this, the executive staff attorney for the State Board replied in writing April 3 that the Medical Board’s Minimal Standards Committee had reviewed AMC/NOMA comments which “assisted the members in developing amended language” on the issue of misconduct and “also assisted the board staff in re-drafting” those relative to terminating patient relationships.

But upon even further review of the amended rules, the AMC/NOMA board wrote again to the OSMB with additional comments considering these revisions.

Specifically, we continue to ask the Board why there is a need to place these items into such strict rules, rules that read like a criminal statute and represent a marked departure from ethical norms. We have asked the OSMB to consider placing the termination rules into a OSMB position statement vs. rule. The OSMB has never published a position statement on terminating the patient/physician relationship. Position statements are used to announce OSMB policy, promote certain minimum guidelines and are meant to put the public and profession on notice of what it considers an appropriate standard of care. The AMC/NOMA is of the opinion that this type of statement would suffice vs. placing these items in a rule that has the force and effect of law.

The OSMB will continue to request comments on these rules as the process moves forward. The AMC/NOMA plans to continue to submit comments on these rules over the next several months.

Members interested in more detailed information on these actions may call Ms. Elayne Biddlestone at (216) 520-1000 or their AMC/NOMA board of directors district representative. ■

Board Adopts Policy on Pay-for-Performance

The AMC/NOMA Board of Directors adopted new policy on Pay-for-Performance, mirroring that of the American Medical Association and reading as follows:

- (1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
 - (a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
 - (b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
 - (c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
 - (d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians;
 - (2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
 - (a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
 - (b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
 - (c) be aware of evidence-based practice guidelines and the finding upon which they are based;
 - (d) always provide care that considers patients’ individual needs and preferences, even if that care conflicts with applicable practice guidelines;
 - (e) not participate in PFP programs that incorporate incentives that conflict with physicians’ professional values or otherwise compromise physicians’ abilities to advocate for the interests of individual patients.
- As pay-for-performance programs begin to impact physician practices, the AMC/NOMA plans to collect information or concerns from our members relative to these matters. If you have comments or input on the policy, please contact Elayne Biddlestone at (216) 520-1000 ext. 321. ■*

Ohio Supreme Court Agrees to Hear Appeal Involving the Practice of Anesthesiologist Assistants

By Jennifer Turk and Marc Blubaugh with Benesch, Friedlander, Coplan & Aronoff, LLP

On December 28, 2005, the Ohio Supreme Court agreed to hear the appeal filed by Joseph Hoffman challenging the Medical Board's regulation prohibiting anesthesiologist assistants ("AAs") from performing epidural and spinal anesthetic procedures and implementing medically accepted monitoring techniques. The appeal was filed after the Tenth District Court of Appeals reversed the decision of the trial court which had invalidated Ohio Administrative Code § 4731-24-04(A) (the "Rule").

The Rule states "[n]othing in this chapter of the Administrative Code shall permit an anesthesiologist assistant to perform any anesthetic procedure not specifically authorized by Chapter 4760 of the Revised Code, including epidural and spinal anesthetic procedures and invasive medically accepted monitoring techniques." Arguing that the Rule was in direct conflict with the statute, Joseph Hoffman, an AA practicing in Cleveland, filed suit on June 10, 2003, against the Ohio State Medical Board demanding a declaration that the rule conflicted with the statute and was therefore invalid.

The trial court agreed holding that the Medical Board specifically negated Ohio Revised Code § 4760.09 which permitted AAs to assist with spinal and epidural procedures as well as medically accepted monitoring techniques by enacting a rule prohibiting AAs from performing these procedures. Additionally, the court held that it would be unreasonable to allow "assist" to mean to carry out procedures as requested by the supervising anes-

thesiologist everywhere else but in the Rule at issue here.

The trial court also found it compelling that the Ohio General Assembly had prohibited certain anesthesia-related practices with regards to certified registered nurse anesthetists and medical assistants, indicating that the Ohio General Assembly chose not to limit AAs from performing spinal, epidurals and medically accepted patient monitoring techniques.

The Medical Board appealed the trial court's decision to the Tenth District Court of Appeals in Franklin County. The Board argued that resolution of this issue depended upon whether the word "assist" is defined according to its "ordinary" definition or its "technical" definition as used in the medical field. Mr. Hoffman maintained that the Rule conflicts with the statute regardless of which definition is applied to the term "assist." Additionally, *amici curiae* briefs in support of Mr. Hoffman were filed by the American Academy of Anesthesiologist Assistants, the Ohio Academy of Anesthesiologist Assistants, Case Western Reserve University, University Hospitals of Cleveland, Parma Anesthesia Associates, Inc., The Anesthesia Associates of Cincinnati, Mercy Anesthesiologists, Inc. and the members of The Academy of Medicine of Cleveland/Northern Ohio Medical Association.

However, on July 21, 2005, the Court of Appeals issued its decision reversing the trial court. The Court of Appeals held the ordinary meaning of "assist" was consistent with a regulatory prohibition upon the performance of the enumerated pro-

cedures under the Rule. Although finding that the Medical Board had compromised its position by adopting a definition of "assist" that supported Mr. Hoffman's position, the Court of Appeals held that the existence of a specialized meaning within the profession, of itself, was not dispositive of the meaning intended by the legislature in drafting the statute as the legislature clearly intended for an everyday meaning to be inferred.

On August 11, 2005, the Court of Appeals granted Mr. Hoffman's unopposed motion for a stay of the Court of Appeals' opinion pending his appeal to the Supreme Court.

On September 19, 2005, Mr. Hoffman filed his notice of appeal to the Ohio Supreme Court. The Supreme Court subsequently agreed to hear Mr. Hoffman's appeal. Mr. Hoffman's brief was filed on March 27, 2006. Once again, Case Western Reserve University; University Hospitals of Cleveland; The Anesthesia Associates of Cincinnati; the members of The Academy of Medicine of Cleveland/Northern Ohio Medical Association; McCallum Robinson Hoyt, M.D., M.B.A.; Mercy Anesthesiologists, Inc.; the Medical College of Ohio Physicians, LLC; the American Academy of Anesthesiologist Assistants; and the Ohio Academy of Anesthesiologist Assistants filed *amici curiae* briefs in support of Mr. Hoffman. The Medical Board's brief is due by the end of April. Oral arguments before the Supreme Court should be held sometime in the fall. ■

"Minute Clinics" Raise Concerns of Continuity of Patient Care

Another issue meriting the attention of the AMC/NOMA board has been the rising incidence of clinics offering medical services opening up in grocery stores and pharmacies across the state. In a March 8 letter to the president and CEO of CVS Pharmacy, **Dr. George Kikano** writes that while the intent of these mini "medical clinics" is assumed to increase access to health care services in the community, the AMC/NOMA board of directors has expressed some specific

concerns on the matter that we felt warranted review and evaluation. These included supervision of the clinics by a licensed physician, medical records retention, privacy issues associated with HIPAA, self-referral implications, public health concerns and medical liability among others. He enlisted a series of direct questions to this effect, and in fact received back enumerated answers both from the Executive Vice President of CVS and the Chief Medical Officer for

MinuteClinic, Inc., based in Minneapolis. A few weeks later another letter was drafted on the subject, addressed to *Crain's Cleveland Business* magazine in response to a published feature on the Akron-based QuickClinic chain. Dr. Kikano wrote: "This concept further fragments health care and steers patients away from their medical home. The 'convenience care' offered is no substitute for the relationship between a patient and a primary care physician. Of

The following article describes the rapid growth of retail-based clinics, a trend that has already reached several regions in Ohio and may soon be coming to the Cleveland area.

“Low Low Prices Everyday”

I'll bet this sign is not hanging in your office window, but it is the sign hanging over the newest trend in healthcare, the Quick Clinic. Big box stores like Wal-Mart and Target, big chain pharmacies and even chain grocery stores are getting into the health care business. They have discovered a lucrative niche and are gearing up rapidly to exploit it.

Quick clinics are small walk-in clinics set up inside big stores and offer rapid, cheap diagnosis and treatment of more common medical conditions. Some have x-ray machines and all have small labs. They offer physicals, diagnoses for a wide variety of common illnesses, and of course treatments readily available on the shelves or at the pharmacy a few steps away. Most are staffed by PA's or NP's. The Big Boxes love the new enterprise. You can bring your sniffly 6 year old to the clinic, pick up a prescription at the store-owned pharmacy, and drop off your photofinishing all in one stop! The marketing is simple and direct — fast, cheap, and customer-driven. Most clinics have a billboard of services and prices hanging right over the front counter, a bit like McDonalds, and the customer/patient picks off the menu a la carte style. “I'd like a prescription for my bronchitis and a flu shot, and oh, could you remove this wart while you're at it?” might be a typical request. The clinic promoters say they are not attempting to replace primary care docs. They say they will readily refer patients with chronic or serious illnesses to a local PCP.

Retail healthcare is run like a fast food business, and in fact many of the top execs were drafted from the fast food industry. MinuteClinic, one of the largest chains, is run by the former Arbys CEO. His company's motto is “you're sick, we're quick!”. The business manager for the Wal-Mart clinics is a recruit from the Waffle House. He says keeping customers happy with syrupy breakfasts is not so different from satisfying them with speedy x-rays. Yum.

Health insurance providers are behind the clinics, too. The prices are much less than a doctor's office visit, and some insurers are offering to waive co-pays if the patient goes to the quick clinic instead of the doctor's office. Wal-Mart may have its employees use the quick clinic instead of doctor's visits to reduce sick leave time. The clinics can charge less, and still generate a better profit margin than a typical office, because they have reduced overhead and eliminated many non-revenue generating activities. There are few send out labs to handle or results to relay to patients, no follow-up phone calls, no struggling with payors over preauthorizations or denials, no front desk staff to book appointments, no “no-shows”, minimal record keeping, no phone time with specialists, no call, no pagers or answering services, and no after-hours coverage. They can skim off the quick and easy illnesses, and leave the complex, time-consuming problems to someone else. Unlike you, the clinics will spend no time providing pay-for-

performance data to get paid. On the revenue side, its cash, credit or insurance on the spot. Some do not accept Medicare or Medicaid.

These clinics are a great convenience and likely to be a huge success with the customer/patients. They will also be profitable for the stores who have them. The question is — What will the quality of care be like? Since it's a customer-driven system, the patient makes the first guess as to the diagnosis. They decide if their illness is a “quick clinic type of illness.” The practitioner, a paraprofessional with limited tools, practicing alone, no previous medical records, no medical history (other than what the customer remembers), no documentation of medical allergies (again, relying on that memory), and no current med list, will do their best to diagnose and safely treat the patient in front of them. There will be time pressure, pressure to offer a definitive diagnosis, and pressure to meet the customer's expectations (fast, cheap, syrupy?). No customer will be happy if they pay their \$50 only to be told they need to go see their doctor, or that they don't need antibiotics for their cold. “The nurse at Target gave them to me last week!” will be the irate complaint. It is episodic, acute illness care, not continuous care with a foundation in prevention, like the kind a patient gets at their primary care doc. The missed diagnosis is the most common reason for lawsuits in primary care, and a fear primary care docs live with daily. I have no idea how they will avoid the malpractice issues that will arise, but I suspect customer/patients will sign a waiver of some sort.

There is no specific legislation regarding this type of clinic, and none being considered.

“Attention shoppers — blue light special! Half off on epigastric pain for the next 15 minutes!”

By Robert Brockmann, MD — Reprinted with permission from the Arapahoe Douglas Elbert Medical Society in Colorado.

Editor's Note: The Academy of Medicine Cleveland/Northern Ohio Medical Association has expressed an interest in the issues discussed above, see related Board Activities, page 4. ■

chief concern for the AMC/NOMA is continuity of patient care. When care is disrupted, a domino effect of negative outcomes can become very real... disruption in the physician/patient relationship; the issue of referring physicians and nonurgent lab work back to the primary care physician for total patient evaluation and appropriate preventative measures, and the risk of duplication of services which will increase the costs and could be harmful to the patient.” The AMC/

NOMA Board plans to request comments and feedback from several state entities regarding the staff oversight and licensure issues at these clinics. Your AMC/NOMA Board will continue to monitor developments on this and keep the membership apprised of any further actions taken.

Any members with comments about the quick/minute clinic issue should call Elayne Biddlestone at (216) 520-1000 ext. 321. ■

By Michael Wise, J.D. / AMC/NOMA Lobbyist

Election Update

The first quarter of 2006 has been busy both politically and legislatively in Columbus and the AMC/NOMA has been very active on behalf of our physicians. On the political front, the Primary Elections will be held on May 2, 2006. The Ballot has been simplified somewhat since my last report.

On the Republican side, Betty Montgomery has dropped out of the race for Governor. That leaves current Ohio Attorney General Jim Petro running against current Ohio Secretary of State Ken Blackwell for Governor. Betty will instead face State Senator Tim Grendell in a primary for Ohio Attorney General. Local State Representative Jim Trakas has dropped out of his race for Secretary of State and he will not run for office in 2006. Greg Hartmann will now run unopposed in that primary race.

On the Democrat side, State Senator Eric Fingerhut has dropped out of the Governor's race leaving Congressman Ted Strickland facing former State Representative Bryan Flannery in that gubernatorial primary. Eric will not be on the ballot in 2006. Montgomery County Treasurer Hugh Quill has dropped out of the race for State Treasurer leaving former State Representative Richard Cordrey running unopposed in that primary.

In the very important Ohio Supreme Court races, the Republicans have cleared the field for their two candidates. For the open seat, previously held by Alice Resnick, the Republicans have chosen former State Senator and current Judge Bob Cupp. He has been endorsed by the Republican State Central Committee and all other interested candidates chose not to file for this seat. On the Democrat side, Ben Espy, a former State Senator and City Councilman from Columbus, and Peter Sikora, a Cuyahoga County Juvenile Court judge since 1989, are competing for Resnick's job. Sikora ran for the high court in 1996, against Justice Andy Douglas.

NOMPAC Endorses O'Donnell and Cupp for Ohio Supreme Court Race

The other race has Republican Justice Terrence O'Donnell running for reelection. Opposing Justice O'Donnell will be the winner of the other primary that pits William O'Neill of South Russell, a second-term judge on the 11th District



Dr. John A. Bastulli confers with Sen. Kevin Coughlin and AMC/NOMA lobbyist Michael Caputo regarding the status of SB 88.

Court of Appeals, against Montgomery County Common Pleas Judge A.J. Wagner. In 2004, O'Neill faced O'Donnell for the unexpired term of Justice Deborah Cook, who had joined the federal bench. O'Neill lost decisively in 2004. AMC/NOMA members will be receiving a letter from the PAC soon to discuss this race and to ask for your financial support. We want to insure that the justices on our Supreme Court interpret the law and do not legislate from the bench. The AMC/NOMA's Political Action Committee (NOMPAC) believes that in order to make certain that this occurs, we need to keep Justice Terrence O'Donnell on the court and elect Appellate Court Judge Robert R. Cupp. These individuals are dedicated to further establish and preserve the principles of judicial fairness. The AMC/NOMA's Political Action Committee (NOMPAC) will be very active in this campaign.

Senate Bill 88 – Mandatory Nonbinding Arbitration – Substitute Bill Now Drafted

As far as legislative activity, the AMC/NOMA staff, lobbyists and physician leadership have focused, not exclusively, on Senate Bill 88. We now have a Substitute Bill drafted. We worked with the Legislative Service Commission over the last couple of months to obtain this new version of SB 88. SB 88 – legislation sponsored by Senator Kevin Coughlin (R-Cuyahoga Falls) provides for a pilot project in Northeastern Ohio to require alternative dispute resolution of medical malpractice claims. Specifically, pursuant to a pilot program administered by the Ohio Department of Insurance and Ohio Supreme Court, the Bill now requires all

medical malpractice claims in Cuyahoga, Geauga, Summit and Lake Counties to be submitted to arbitration. This shall be done before a lawsuit is filed and the Bill provides for a tolling of the Statute of Limitations of the Claim. Significant changes in the Substitute Bill include:

- The arbitrators chosen by the parties must be a medical expert in the same area of specialty that is the subject of the claim,
- The third arbitrator, chosen by the parties arbitrators, serves as chair of the panel and must be from the American Health Lawyers ADR service,
- The arbitrators do not make findings regarding damages. The arbitrators rule on the applicable standard of care, if the defendant deviated from that standard, and if that deviation was the proximate cause of the claimant's injuries,
- Any party may reject the ruling of the panel and proceed to court, but they become liable for opposing attorney fees if they then do not prevail at trial,
- The parties, by mutual consent, may at any time agree to mediate their dispute. If the dispute is not successfully mediated, the dispute shall be arbitrated before being eligible for court proceedings.

We expect this Substitute Bill to be accepted by the Senate Insurance Committee when the Senators return from their spring recess. That return is expected the first week in May after the primary. The Senators will be in session for no more than a few weeks before recessing until after the November elections. Best case for SB 88 would be to
(Continued on page 7)

pass the Senate this spring and then receive consideration in the House in the fall. The Legislation has come a long way and we will enthusiastically push the process for the balance of 2006. Several AMC/NOMA members, including Drs. Bastulli, Clough, Cudnik, Myles and Beyer, have already agreed to return to Columbus to testify for SB 88. If you are interested in testifying in support of SB 88, please contact the AMC/NOMA executive staff at (216) 520-1000.

**Other Bills Under Review
By The AMC/NOMA**

HB 117 - Alternative Health Care

AMC/NOMA is working with sponsors and committee members on a number of other Bills. Bills that the AMC/NOMA oppose include HB 117 by Rep. Reidelbach to expand the availability of alternative health care services. AMC/NOMA opposes because of concerns about the lack of regulatory oversight.

HB 502 - Medical Records

We also oppose HB 502 by Rep. Ujvagi to provide for one complimentary copy of a patient's medical record. AMC/NOMA opposes because of the unfunded mandate.

HB 46 - Tax Deductibility for Medical Expenses

Bills that the Academy supported include HB 46 by Rep. Schaffer to increase the tax deductibility for medical expenses. AMC/NOMA supported for the positive economic benefit to patients. This Bill is now law in Ohio.

HB 287 - Freestanding birth centers

We also supported HB 287 by Rep. Aslanides to provide for a licensing exemption for certain freestanding birth centers. AMC/NOMA supported this exemption and also a subsequent amendment to protect physicians.

The amendment was offered in the Senate after the Bill had passed the House. The Amendment was offered by Senator Jordan and was approved to prohibit lawsuits based on wrongful birth or wrongful life causes of action. These actions are brought on behalf of both parents of children with birth defects and the children themselves. The Ohio Supreme Court had ruled in 200 that wrongful life claims are not recognized. In 2005, the Court heard arguments regarding wrongful birth. In April of this year, the Court ruled that parents do not

have a cause of action in Ohio for wrongful birth. This decision is a victory for physicians. Dissenting from the core holding were justices Pfeifer and Resnick. Three Justices disagreed with allowing damages of any kind, saying the matter was best left to lawmakers "because it involves important matters of public policy." These particularly pro-physician justices were Terrence O'Donnell, Evelyn Lundberg Stratton and Judith Ann Lanziger.

Governor Taft went on to sign into law HB 287 in April 2006. Physicians in Ohio now have both legislative and judicial protections in the wrongful birth/life area of the law. Ohio joins six other states with similar protections, Idaho, Minnesota, Missouri, Pennsylvania, South Dakota, and Utah.

Enacted bills

HB 257 - Influenza Vaccinations

AMC/NOMA also tracked three other Bills that have now become law in Ohio. HB 257 was introduced by Rep. John Hagan on May 17, 2005, and referred to House Health Committee. The Bill requires, with certain exceptions, that nursing homes and residential care facilities offer influenza vaccinations to all residents and pneumococcal vaccinations to residents 65 years of age or older. It also requires, with certain exceptions, that hospitals offer influenza and pneumococcal vaccinations to patients 50 years of age or older who are admitted for 24 hours or longer. The Governor signed the Bill on March 13, 2006.

SB 53 - Pseudoephedrine Restrictions

This bill was introduced by Senator John Carey on February 9, 2005 and referred to the Senate Health, Human Services and Aging Committee. SB 53 regulates the manner in which medication containing pseudoephedrine is distributed. The bill places restrictions on

products with ONLY pseudoephedrine as the active ingredient. For products such as these, the proposal requires the product to be placed behind a counter, limits purchasing to two packs (or 6 grams) at a time and requires a photo ID (purchaser must be at least 18 years old). The Bill was signed by the Governor on February 9, 2006.

SB 154 - Physician Assistants

SB 154 was introduced by Senator Lynn Wachtmann on June 14, 2005 and referred to the Senate Health Committee. The bill, a companion to HB 305, would allow physician assistants to prescribe medication and generally have more authority to practice by requiring them to attain a master's degree. Provides for the issuance by the State Medical Board of "certificates to practice," rather than "certificates of registration" as a physician assistant, and specifies that a certificate to practice constitutes the state's licensure of physician assistants. SB 154 requires, beginning January 1, 2008, that a person have a master's or higher degree to obtain a certificate to practice as a physician assistant. Exempts a physician assistant from the master's degree requirement if the physician assistant is licensed by another jurisdiction prior to January 1, 2008. Eliminates the Board's issuance of temporary certificates to physician assistants who have not yet obtained certification by the National Commission on Certification of Physician Assistants. The Bill was reported from Committee on October 20, 2005 and signed by the Governor on February 14, 2006.

The Legislators have recessed until after the May primary. They will return for approximately six weeks before recessing again until after the November elections. We expect more activity on physician-related legislation and will provide you with another update in the next issue of *Physician Magazine*. ■



VP of Legislative Affairs John Bastulli, MD, spends time discussing legislation with Sen. Kirk Schuring and Sen. Ron Amstutz.

Building an “On-Ramp” to the Healthcare Information Superhighway...

It's ridiculous, but we've all been there — the patient with a documented allergy given the wrong medicine; the patient with a chronic illness carting a crate full of charts; the patient you know well admitted to another hospital because the emergency physician didn't know their history; and the reams of “digital” results converted to paper for delivery to your office via fax or U.S. mail. That's just the beginning of a long list of absurdities in modern medicine that have a common thread — our inability to deliver and provide access to clinical data where its needed, when its needed, to whom its needed in a private, secure, and confidential manner. The result is a serious challenge to our ability to provide care that is safe, efficient, and of the highest possible quality.

Layer upon this the impending data challenges of “Pay-for-Performance” coupled with graying baby boomers, and you have an undeniable case for transforming the way we do business. Our region's hospitals are moving into the world of EMR, CPOE, and portals at varying paces. Physician offices are moving along parallel pathways. We've all heard the horror stories of good practices dragged to their knees by the demands of EMRs. Programs intended to make things better have disrupted office flow, created chaos, and destroyed teams. In almost all cases, crucial failure points included poor user interfaces, lack of adequate support, cost, and the EMR's inability to access and use data already available in a digital format. Why can I use an ATM to get my money anywhere in the world but I can't get the EKG that was done across the street?

There's not enough time here to discuss why medicine has been so slow to adopt information management practices that have become common place in most other industries. Moving medicine into the information age is a priority for the U.S. government and most business sectors because they can't afford to continue paying for our inefficiencies. In April, 2004, President Bush declared that, within ten years, we would create a national health information network (NHIN) that would enable every American to have access to an electronic medical record that they controlled.

That declaration was followed by creation of the Office of the Nation Coordinator of Health Information Technology (ONCHIT) which answers directly to the Secretary of Health and Human Services. In a few short years, ONCHIT has partnered with several public-private collaboratives (i.e., eHealth Initiative, Connecting for Health, HIMSS, IHE, HL7, etc.) to begin to bring order to the “Wild West” world of healthcare information technology (HIT).

Significant strides have been made in making data interoperable. Increasingly, individual data points cannot only be moved between programs from different vendors, but the data points actually mean the same thing when

they're combined and compared. Since most health care is local, the developing NHIN is being built upon regional health information organizations (RHIO). They act as coordinating points for both data flow and the policies, procedure, finances, and politics that are inherent to such efforts.

There are over 200 RHIOs in some stage of development throughout the United States, including one that we're developing in northeast Ohio. The NEO RHIO began as a cooperative effort between major hospitals in the Cleveland-Akron-Canton corridor (Cleveland Clinic, MetroHealth, University Hospitals Health System, Akron Children's Hospital, Akron General Medical Center, Summa Health System, Aultman Hospital, and Mercy Medical Center). It has quickly expanded to include physicians through county medical societies, hospital associations, insurers, business groups, quality improvement organizations, and other stakeholders.

NorTech, a technology-based economic development organization for northeast Ohio, is acting as convener for this process. They do not want to be the owner or operator of the RHIO once it's formed. I've agreed to serve as the project lead. We're also working in cooperation with a state-wide initiative to informally link our effort with nascent projects throughout Ohio. Several of our member hospitals are also working with Northrup Grumman Corporation on one of the national NHIN infrastructure projects. These projects are designed to develop mechanisms to link RHIOs together across the country. While important, the Northrup Grumman project should have no impact on the work we're doing at NEO RHIO.

We've now formed an Interim Executive Task Force, which is overseeing the project, and four workgroups — Mission/Vision, Governance, Finance, and Strategy/Applications. We're studying our region to better understand our needs, our resources, and the way to structure the RHIO to best serve all key stakeholders. We're also wrestling with the issue of expansion. We started small, believing it was foolhardy to move forward with a large group if we were unable to achieve buy-in from the core group that is now engaged. There are an enormous number of stakeholders from a much larger geographic region who now want to participate. We're hard at work developing governance, operations, and financing structures to make it possible to expand the number, breath, and geography of membership. We must balance the need to be inclusive against the need to get things done in a timely manner. For those of you who might feel left out, that is certainly not our intent. There is more than enough work for everyone!

Once developed, the NHIN and its component RHIOs will likely transform the practice of medicine. We'll find uses for these tools that can't even be imagined today. President

Eisenhower built the freeway system to be able to evacuate major cities in the event of a nuclear attack and to rapidly mobilize troops to defend our shores. Though neither has been necessary, no one can argue with the transforming effect the freeway has had on every aspect of American life. Similarly, the Internet was developed to facilitate secure exchange of academic and military research data. Mobilizing healthcare data through the NHIN can have a similar transforming effect on the way we care for our patients for decades to come.

While we're still trying to decide what the NEO RHIO will look like when it is “grown up,” it is instructive to learn from what others have done. The key to the process is developing trust between entities that are not used to working together. Sharing something of such critical importance as clinical data with your competitor is an intimidating proposition. It has been said that, while the technology and finances are challenging, it is the politics that will separate a successful RHIO from one that never achieves its potential.

Experience in many locations, including HealthBridge in Cincinnati, has shown that a good first step might be to use a RHIO to deliver results from hospitals and outpatient labs to clinicians. This is a costly effort which is required of every provider, and it does not require the hospital to share its data directly with other hospitals. Using this model, each hospital would create interfaces to the RHIO database which would then convert the hospitals data to a common format and collate the data from all labs to an “in box” for each physician. The RHIO would also develop interfaces to a core set of commercial office EMRs. If the community physician used such an EMR, results from all labs would be directly deposited into the patient's EMR record without the time delays, transcription error, and wasted human effort we currently experience. If an office does not have an EMR, the RHIO might act as a “mailing service”. Results from multiple labs would be collated, sorted by physician and patient, and delivered by fax, mail, or courier. HealthBridge is currently delivering 1.4 million results from 16 hospitals to over 4000 physicians in Cincinnati each month at far less than half of what it used to cost to do so.

A logical next step might be to develop two-way communications to facilitate data flow between providers. MA-SHARE was developed in the Boston area to link all emergency departments to all providers, starting with hospitals and now an increasing number of physician offices, clinics, pharmacies, and public health entities. This linkage was specifically designed to address problems inherent to patients transported to ERs other than their medical home. It has improved the timeliness of care and reduced costly duplicative testing and unnecessary admissions. Similar

(Continued on page 9)

mechanisms could be used to facilitate access to clinical data when patients are referred from primary care physicians to consultants, thus eliminating the “crate full of charts” phenomenon and significant delays.

The availability of digital clinical data and improved communications with other providers will likely drive increased clinician migration to EMRs. In the US, most healthcare is still provided in 3-5 physician practices. Unfortunately, most small practices have neither the finances nor the expertise to operate 24-hour data centers. The personnel, equipment, backup capabilities, and redundancy necessary to secure critical medical records from hackers, burglars, fire, flood and other disasters are best shared between larger groups of providers.

In New York, the Taconic IPA has found that their RHIO is the ideal vehicle to serve that role. Physicians picked the 4-5 EMRs that best met their needs. The RHIO “hosts” the applications and provides all maintenance, updates, service, and training. Each practice’s data is kept in its own “data vault” which segregates it from other practices. They think of it as having their hard drive located in the secure confines of the RHIO data center rather than under a desk in their back office. From a functionality standpoint, the user experience with the EMR is identical whether it is hosted locally or by the RHIO. The practices are charged for the service using a formula that results in a cost significantly lower than what practices have incurred when they implemented an EMR on their own.

As you might imagine, data mobilization will have equally profound effects on the way we do chronic disease management, quality improvement, medication prescribing, education, research, and the way that we’re paid. Pay for performance would not be nearly as intimidating if the data needed to support payment was created and extracted as part of the process of care. In this age of threats from biologic agents such as avian flu, anthrax, etc., a functional RHIO will provide critical syndromic surveillance capabilities. It is not unreasonable to see the EMR incorporated into our specialty boards’ continuous certification processes. Ultimately, patient portals will allow the patient to have much greater access to and control over their records and to play a much greater role in their healthcare. The possibilities are endless...

Whenever RHIOs are discussed, two questions are always raised. Who will have access to my data / will it be safe? Who’s going to pay for this?

When data is made available outside the customary confines of the physician-patient relationship, issues of confidentiality, security, authorization, and authentication become increasingly important. Ultimately, the patient must remain in control of who has access to their data. In a “connected” world, computers can make good things and bad things happen at the speed of light. This is certainly true with health data exchange. While a discussion of this complex topic is far beyond the scope of



Dr. Brian Keaton (r) spends a moment with Dr. David Brailer prior to his presentation.

this report, you can be sure that an enormous amount of work is ongoing nationally to address these issues.

Finances are always a concern. Most Americans believe we already spend enough money on health care. We just spend it the wrong way. We believe that the NEO RHIO can be created with a significant contribution of extramural funds in the form of grants, etc. We also believe that a RHIO must operate using a business plan that ensures sustainability based on revenue and expense. We understand the historic mismatch in the ROI equation and are working hard to assure that those who make the investment reap the return on that investment.

We’re in the early stages of creating a north-eastern Ohio “on-ramp” to the healthcare information super highway. We welcome your participation and your support.

Brian F. Keaton, MD, FACEP
NEO RHIO Project Chair
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Brian F. Keaton, MD, FACEP

Brian F. Keaton, MD, is a recognized leader in the fields of emergency medicine, medical education, medical informatics, organized medicine, and government affairs. He trained in emergency medicine and is core faculty at Summa Health System’s Department of Emergency Medicine. He is also President-Elect of the American College of Emergency Physicians (ACEP). Dr. Keaton is currently leading the effort to create a regional health information organization (RHIO) linking healthcare providers, resources, and patients in Northeast Ohio.

Editor’s note: The AMC/NOMA is an integral partner in the work being done to create the NEORHIO. The AMC/NOMA has committed staff, leadership and nominal funding toward the development of a business plan for the NEORHIO. The AMC/NOMA will continue to update our membership on the progress of this project. ■

Health IT Could Succeed Through Regional Collaboration

(Continued from page 1)

and the understanding of *who* exactly is responsible for addressing it. The patient? The doctor? Health plans? Hospitals? “They cannot fix it alone,” he said. “And neither can the federal government. We can get there in steps — the government can move it forward but they lack the tools. We want person-centered interoperable data. We want patients to get the health care information they need.”

A supportive infrastructure is currently lacking, however, to integrate all the systems being utilized already across the country. Dr. Brailer indicated that the government first has set up the Health Information Technical Standards Panel (HITSP) to implement much-needed standards and is planning to fund the Nationwide Health Information Network (NHIN) in an effort to stimulate the industry and build the capacity to make sure actual data can, and is, shared.

He spoke of the development of the Certification for Health Information Technology to make vendor/purchaser determinations. In June, CCHIT will distribute information on products that meet certain criteria, review vendors and then provide their report on these vendors. He also touched on privacy and how HIPAA, based on a paper system, will be forever changed when widespread EHR is in use.

Dr. Brailer stated that there are many regional and state projects happening right now all over the U.S. and his agency encourages this type of collaboration and work. In fact, he said no big health plans or employers could do the work only a regional approach can, addressing specifics to that area, and the like. Of interest to physicians, he said the best approaches will necessarily lead to the best clinical results.

“Your patients have the same needs as other patients across the U.S. Patients need to see that they have convenience, access, control and they are confident that there will be reduced errors and better care. It is very important what the NEO RHIO is doing here in NE Ohio. It shows an ability to come together and share the vision and be a leader in this process.”

Editor’s Note: Dr. Brailer recently announced his resignation effective May 19 following two years as the National Coordinator for Health IT, a position created by an executive order of President Bush. ■

Court of Appeals Decision: HIPAA Does Not Pre-empt Ohio Law

By John T. Mulligan, Esq., McDonald Hopkins Co., LPA

An issue which regularly confronts physicians involves determining when they may (or must) disclose patient-related information or materials to third parties. In this regard, not only must physicians comply with the confidentiality restrictions imposed upon them by Ohio law, but since 2003, they have had to comply with the federal privacy regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA").

HIPAA will control over any contrary provision of state law, with one very significant exception. That exception is that to the extent that state law is more restrictive (meaning, generally, that it mandates greater confidentiality for physician-patient communication) state law will control. The net effect of this is that in determining whether to disclose patient related information, both HIPAA and Ohio law must be consulted.

The interplay between HIPAA and Ohio law was the subject of a court opinion issued in late December, 2005 by the

Summit County Court of Appeals in the case of *Marvin Grove, et al. v. Northeast Ohio Nephrology Associates, Inc., et al.*

Marvin Grove was injured in an automobile accident caused when the driver of an automobile, Carmela Pleli, lost control of her vehicle. He alleged that she was driving in an impaired state as the result of having just completed a dialysis treatment, and that the defendants (a professional corporation of nephrologists and, apparently, a dialysis center) had breached their duty by permitting her to drive. The case was filed as a malpractice case even though the defendants had not provided medical care to the plaintiff.

Following the filing of the case, the plaintiff requested that the defendants produce the complete patient chart of Ms. Pleli. They objected to the disclosure. The trial court considered the request for the information and the objection, and issued an order declaring that although the plaintiff was not entitled to copies of Ms. Pleli's medical records, he could receive information related to the treatment Ms. Pleli had received at the time she was in the defendants' offices. This ruling was appealed by the nephrologists and the center.

It is to be noted that the records that were being sought were those of an individual who was not a party to the litigation. While the suit arose out of the operation of a motor vehicle, the Complaint was for medical malpractice. Ms. Pleli, the driver, had previously settled with the plaintiff.

The initial issue dealt with by the Court of Appeals was whether the nephrologists and the center had standing to appeal the trial court's order to disclose confidential information about their patient. The plaintiff had argued that only the patient had the right to appeal that decision and, further, that the existence of an order of the trial court would shield them from any liability for disclosing information.

The Court of Appeals ruled that "medical professionals generally, and Appellants specifically, have standing to appeal a discovery order that requires them to violate the mandate of the statutory physician-patient privilege." The Court of Appeals did not go so far as to say that the nephrologists and the center had an obligation to contest or appeal the trial court's ruling in a situation such

CASE AT A GLANCE

Marvin Grove, et al. v. Northeast Ohio Nephrology Associates Inc., et al.

Venue: Ohio Court of Appeals, 9th Judicial District

At issue: Whether physicians can assert privilege on behalf of their patients when doctors are asked to produce medical records, and whether HIPAA preempts state law protecting those records

Impact: The court ruled that Ohio doctors have legal standing to defend their patients' privacy rights as a third party and that stricter state law preempts federal HIPAA rules governing when doctors must disclose patient information in response to a court order or subpoena.

as in this case in which the patient, while not consenting to the disclosure, was not contesting it. Thus, this case leaves unanswered the question of how far a physician who is not a party to a lawsuit must go in contesting the disclosure of patient information.

The Appeals Court next turned its attention to the federal and state laws which deal with physician-patient confidentiality. The Appeals Court dealt with the confidentiality issue by noting, first, that Ohio law does contain a provision protecting the confidentiality of the communications between the nephrologists and Ms. Pleli. It also noted that there was no evidence in the record that Ms. Pleli had consented to the disclosure of her records (indeed, she had refused to return the calls and letters of the plaintiff's attorney), nor that there was any statutory exception to the disclosure of those communications under Ohio law.

The Plaintiff argued that HIPAA preempts state law on the subject and thus permits the discovery of Ms. Pleli's information. The court responded by noting that HIPAA specifically provides, in part as follows: "the provision of state law relates to the privacy of individually

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identifiable health information and is more stringent than a standard, requirement or implementation adopted under [these regulations]". The court ruled that in this case Ohio law was more stringent than HIPAA.

On appeal, the Plaintiff then argued that a trial court could require the disclosure of the information as long as the non-party patient's identity (in this case Ms. Pleli's identity) was protected. The Appeals Court easily dismissed this argument noting that there was no way in which her anonymity and privacy could be preserved even if there were a redaction of her personal information, in that everyone would know whose patient information it was.

There are lessons to be learned from this case:

- (1) Physicians, even if they are not parties to a lawsuit, have the right (and, perhaps, the duty) to contest trial court decisions involving their disclosure of patient-related information.

- (2) In any situation in which protected health information is sought to be disclosed, both HIPAA and Ohio law must be consulted. If either HIPAA or Ohio law would prevent the disclosure of the information, then the information cannot be disclosed.

Our office regularly receives copies of subpoenas issued in court cases in which our physician clients are requested to produce protected health information involving their patients. Often this occurs in non-malpractice cases in which our client was the treating physician, and was not a named party to the litigation. Often these subpoenas are issued in a manner that violates both Ohio Law and HIPAA. Physicians need to remember that, while a subpoena should not be ignored, unless it is issued in a manner which complies with the requirements of both HIPAA and Ohio law, physicians should not comply with it, and, if necessary, seek a court order to quash the subpoena. ■

The Board of Directors recently approved changes to The Academy of Medicine Cleveland/Northern Ohio Medical Association Bylaws. ***In accordance with Article VIII of the Bylaws, the Board voted to publish the following proposed amendment.***

"The Secretary Treasurer shall serve for a term of ~~two~~ ~~(2) years~~ ONE (1) YEAR and continue to be a member of the Board of Directors by virtue of his/her election as Secretary-Treasurer. The Secretary-Treasurer shall ~~not~~ be eligible for re-election to ONE successive terms"

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Medicare Claims Appeals System Issues Final Rule

By Amy Leopard

The Centers for Medicare and Medicaid Services' final rule for the new Medicare claims appeals system substantially revises appeals rights for health care providers. At the same time, the administrative law judge appeals function is now being transferred from local Social Security offices and consolidated in a new Medicare administrative law judge court, with the Midwestern Regional Office in downtown Cleveland.

These changes could mean considerable financial consequences for Part A providers (hospitals, home health agencies, nursing homes, etc.) and Part B providers (physicians and medical equipment and supply companies), which typically derive nearly half their revenues from Medicare.

Here are 10 suggestions for providers to better manage appeals of Medicare denials:

Manage denials. In a recent report, the Government Accounting Office said only 5 million of 158 million claims denied by Medicare were appealed. One advantage under the new rules is that Medicare cannot recoup overpayments until an independent decision has been made on carrier and intermediary reconsiderations. Given the favorable track record on appeals and tightened decision timeframes, providers proactively should manage Medicare denials and consider filing timely appeals.

Pursue Appeals. Providers may appeal to the new qualified independent contractors, which are independent organizations the Centers for Medicare and Medicaid Services has engaged to decide the appeals that Part B hearing officers previously decided. Appeals to qualified contractors must be filed within 180 days of an unfavorable reconsideration.

Appreciate the type of hearing afforded. The independent contractor will perform an "on-the-record" review based on the documentation and any briefs or position statements the provider submits. For Part A providers, this is an additional stage in the claims appeal process. For Part B providers, this review will replace the previous opportunity to appear in person before a fair hearing officer.

Identify legal arguments early. Under the new rule, an independent con-

tractor appeal request should include the basis for the appeal and all evidence and allegations of fact and law. Each time a provider submits additional evidence, the contractor gets an additional 14 days to decide the case, extending the normal 60-day timeframe. Providers must organize their appeals and consider all possible defenses and supporting materials needed at the earliest possible date.

Organize evidence early. Providers should prepare expert medical opinions and scientific literature to support the appeal as soon as they understand the basis for the denial. Under the new rule, medical necessity decisions at the qualified independent contractor level require a review of the medical evidence in the record by physicians for physician cases, and by appropriate health care professionals for other cases.

Appeal to an administrative law judge. Unfavorable independent contractor decisions can be appealed to an administrative law judge, an attorney who will make a decision without regard to what has been decided before. Administrative law judge appeals must be filed within 60 days of an unfavorable independent contractor decision.

Develop a strategy for testimony. Administrative law judges often will use video conferencing in lieu of an in-person hearing. Providers can request in-person hearings for special circumstances, such as the provider's proximity to a law judge's office or when the appeal raises complex and challenging issues. In Cleveland, the personal administrative law judge hearing approach is advisable when in-person witness testimony might help to explain medical records better or assist with technical issues.

Prepare for participation. When qualified independent contractors organize completed case files to send to the administrative law judges, they can request that the Centers for Medicare and Medicaid Services participate in provider appeals. Unlike the old system, the Medicare and its contractors can choose to participate in the appeal. The Centers for Medicare and Medicaid Services can file briefs or testify by video conferencing. The effective cross-examination of adverse witnesses now needs special attention.

Appreciate which rules apply. The new rule establishes a hierarchy of the Centers for Medicare and Medicaid Service policies that bind the decision-maker at each level. Local medical review policies and other informal guidance are not binding on administrative law judges, but must be given substantial deference or, if not followed, explained in the decision. Providers should give the decision-maker a coherent and persuasive reason to disregard any policies that should not be applied, preferably before the records are reviewed.

Understand there will be confusion. The changes in appeals procedures, independent contractor functions, and new administrative law judge court system are a work in progress. Implementing changes of this magnitude always entails a transition period during which there will be confusion, especially with the number of agencies involved.

Ms. Leopard is a Partner in the Health Care practice area of the Cleveland law firm of Walter & Haverfield LLP. ■

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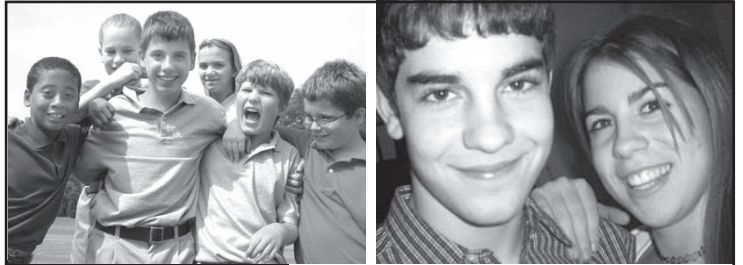
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Medical Error Reporting Under the New Patient Safety and Quality Improvement Act of 2005

The Patient Safety and Quality Improvement Act (PSQI Act) is intended to encourage voluntary medical error reporting to a Patient Safety Organization (PSO) by protecting patient safety data from disclosure so that health care providers can report medical errors without fear of being sued. The PSO will analyze the information reported, provide feedback to the reporting provider, and may voluntarily report nonidentifiable information to a network of databases that will be created and maintained by the Department of Health and Human Services (DHHS).

The PSQI Act provides broad confidentiality and privilege protections in civil and criminal proceedings to patient safety work product reported by providers to a PSO. Patient safety work product is protected against discovery in federal state, or local civil, criminal, or administrative proceedings and is not subject to subpoenas or orders related to these proceedings.

Patient safety work product is broadly defined as any data, reports, records, memoranda, analyses (such as root cause

analysis), or written or oral statements that are assembled or developed by the provider for reporting to a PSO and are reported to a PSO, or that identify or constitute the deliberations or analysis of, or identify the fact of reporting to, a patient safety evaluation system. As in the case of a state peer review privilege statutes, the definition specifically excludes original source information such as medical records or billing and discharge information. More importantly, the definition also excludes information that is collected, maintained, or developed, or that exists, outside of a patient safety evaluation system, even if that information is ultimately reported to a PSO. A patient safety evaluation system is a system that collects, manages, or analyzes information for reporting to or by a PSO.

The goal of the PSQI Act is to permit providers to conduct honest quality assessments without the fear that the assessment will ultimately be used against them in litigation. If a provider wishes to protect peer review, patient safety, sentinel event, quality assurance, and similar information under the PSQI

Act, the provider must:

- Modify policies and procedures and centralize the flow of information from these activities through a patient safety evaluation system, and
- Actually report the information to a PSO (this requires the creation of an affiliation with a PSO).

Properly structured, the PSQI Act provides federal protection of quality data where privilege at the same level has been diluted.

A person who discloses patient safety work product is subject to a civil money penalty of up to \$10,000 for each violation. The PSQI Act specifically provides that penalties cannot be imposed under both the PSQI Act and the HIPAA Privacy Rule for the same act or omission.

Because the DHHS has not issued regulations or guidance under the Act, providers should carefully consider what information, if any, they wish to develop, evaluate and ultimately report to a PSO.

Editor's note: Once the DHHS has issued regulations or guidance under this Act, the AMC/NOMA will provide additional information on this matter to our members. ■

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Tort Reform Ushers in New Reporting Requirement May 1

In an effort to monitor the effect tort reform is having on medical malpractice litigation, Ohio's General Assembly has enacted Revised Code §3929.302. This new statute requires that each authorized insurer, surplus lines insurer, risk retention group and self-insurer report the costs of defending medical liability claims and the amount of any judgment or settlement on behalf of health care providers and health care entities. The information must be sent to the Ohio Department of Insurance (ODI) at least annually for any medical claims asserted against a risk located in Ohio if the claim resulted in any of the following: 1) final judgment; 2) settlement; or 3) a final disposition of the claim resulting in no indemnity payment on behalf of the insured.

The report must contain the following information: 1) the name, address and specialty of the insured; 2) the insured's policy number; 3) the date of the occurrence that created the claim; 4) the name and address of the injured person; 5) the date and amount of the judgment, if any, including a description of the portion of the judgment that represents economic

loss, noneconomic loss and, if applicable, punitive damages; 6) in the case of a settlement, the date and amount of the settlement; and, 7) any allocated loss adjustment expenses.

Notably, the information required in these reports is confidential and privileged, and is not considered a public record. Thus, the information is not subject to discovery or subpoena. ODI will use the reported information to prepare annual reports that summarize closed claims on a statewide basis, and also by specialty and geographic region.

Such data *must* be submitted through a secured application on the ODI Web site. ODI requires the closed claims data for the previous calendar year be reported by May 1. By May 1, 2006, all claims closed since the rule's effective date of Jan. 2, 2005 must be reported through the Medical Liability Data Collections Application. A link to this can be found at www.ohioinsurance.gov/agent/medmal.htm

The Department may impose a fine of no more than \$500 against any entity that fails to timely submit a report required under the statute.

This new reporting requirement does not relieve professional liability carriers from other reporting requirements imposed by Ohio and federal law. Pursuant to ORC §4731.224, professional liability insurance carriers must notify the Ohio State Medical Board within 30 days of the final disposition of any written claim for damages where the disposition results in a payment exceeding \$25,000. The notice must contain the following information: 1) the name and address of the person submitting the notification; 2) the name and address of the insured who is the subject of the claim; 3) the name of the person filing the written claim; 4) the date of disposition; and, 5) if applicable, the identity of the Court in which the final disposition of the claim took place.

All reports received by the SMB are confidential and not subject to discovery or introduction into evidence in any federal or state civil action involving a health care professional or facility.

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Physician Voluntary Reporting Program

By Robert R. Kamps, MD, Medical Director Palmetto GBA

As part of its overall quality improvement efforts, the Centers for Medicare and Medicaid Services (CMS) launched the Physician Voluntary Reporting Program (PVRP) on January 3, 2006. This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of Medicare beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered. Under the voluntary reporting program, physicians who choose to participate help capture data about the quality of care provided to Medicare beneficiaries in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care.

Before payment methods can be based on the quality of care, there must be a way to measure and evaluate quality. Accordingly, CMS is committed to the development of reporting and payment systems that will support and reward quality. The quality measurement initiatives aim to empower providers and consumers with information that would support the overall delivery and coordination of care, and ultimately support new payment systems that provide more financial resources to provide better care, rather than simply paying based on the volume of services. While the usual source of the clinical data for quality measures is retrospective chart abstraction, data collection through this process can be burdensome. Consequently, the voluntary reporting program focuses on ways to obtain valid quality measures as efficiently as possible. All physicians electing to participate in this voluntary program have the opportunity to influence the ultimate outcome of the process.

The reaction of the physician community to the Physician Voluntary Reporting Program to this point has been mixed. Some see the program as an additional uncompensated administrative burden and have chosen not to participate. Others view PVRP as a sneak preview of a possible CMS future pay-for-performance plan and are willing to pilot a relatively simple method of reporting data without investing in expensive health information technology. Physicians who choose to participate will be able to receive feedback on their performance as well as to provide input on how quality reporting can be improved and made even less burdensome.

Also, the measures being used are likely to be similar to the ones that commercial payers will be using, so participating may help physicians with commercial pay-for-performance programs. Pay for performance is not a new concept, and physicians have dealt with similar private sector programs. The private insurance industry has pay for performance

programs that have largely been limited to primary care physicians and chronic diseases. Many academic institutions in major metropolitan markets are already participating in private payer quality initiatives.

Outlined below are the key elements of the Physician Voluntary Reporting Program.

How Will Data Be Gathered?

- New G-codes reported on Medicare claims. The G-codes are an interim step until electronic submission of clinical data through EHRs replaces this process. Medicare expects to work with some physician groups that have already adopted EHRs to assist with this transition.
- Electronic health records (EHRs) (not in widespread use at this time). CMS is working with physicians to achieve the goal of adopting EHRs in their offices, building on reporting based on the pre-existing claims based system.
- Quality Improvement Organizations (QIOs), which are also CMS contractors, will be helping physicians move toward a more dynamic and evolving public reporting and pay-for-performance quality improvement environment. QIOs are providing assistance to help physicians create systems so that the measures can be more easily reported.

How Will Measures Be Developed?

Measures should be:

- Valid
- Reliable
- Evidence-based
- Relevant for consumers, clinicians and purchasers
- Developed through open and transparent processes
- Implemented in a realistic manner, with minimal burden on physicians so as not to discourage appropriate care.

Reporting Quality Measures

- 36 evidence-based clinically valid measures are part of the guidelines endorsed by physicians and medical specialty societies and are the result of extensive input and feedback from physicians and other quality care experts. The 36 quality measures are arranged in sets of measures, with multiple G-codes in each set. The physician will report the appropriate G-code that represents the clinical services furnished with regard to a specific measure set. CMS will begin this program with a smaller "core starter set" of 16 PVRP measures. Physicians may still report all 36 measures; however, summary reports from CMS will only be available for the 16 core measures.

- Performance will be calculated using the G-code and the appropriate services/condition.
- The reporting rate will be calculated by CMS as a percentage for each of the 36 measures.
- Additional information on quality measurements can be found in the CMS Internet only manuals Publication 100-19 Demonstrations by following this link: <http://www.cms.hhs.gov/manuals/cmsindex.asp>
- Read more about CMS instructions to contractors in Change Request 4183: http://www.cms.hhs.gov/manuals/pm_trans/R35DEMO.pdf
- For more instructions written for physicians and staff, read the complete MLN Matters article: <http://www.cms.hhs.gov/MedlearnMattersArticles/> (go to 2005 articles and search for "4183")

Physician Use of G-codes – General Information

- G-codes, when applicable, should be reported in addition to CPT and ICD-9 codes required for appropriate claims coding.
- G-codes do NOT substitute for CPT and ICD-9 codes requirements for payment.
- G-codes are not associated with a separate fee, and will NOT be individually compensated.
- G-codes are not specialty specific. Therefore, a medical specialty may report G-codes classified under other specialties; however, CMS anticipates that the reporting of certain G-codes will be predominated by certain specialties.
- The failure to provide a G-code will NOT result in denial of a claim that would otherwise be approved, and thus submission of a G code is voluntary.

Physician Use of G-codes – When to report

G-codes are reportable when all of the following circumstances are met:

- The G-code reported on the claim relates to a covered diagnosis, covered treatment(s) or covered preventive service(s) that are applicable to the beneficiary.
- The G-code is directly relevant to the specific service(s) provided to the beneficiary by the practitioner reported on the claim.
- The G-code represents medically necessary and appropriate medical practice under the circumstances.
- The basis for the G-code is documented in the beneficiary medical record. ■

AMC/NOMA Weighs In on DTC Advertising and its Impact on Patients (Continued from page 1)

on advertising over research and development. To this, Dr. Kikano pointed out, however, that recent recalls of certain drugs may have been better served with more detailed postapproval study. Several of the shared comments and many callers from the community expressed their concern regarding the exponential increase in DTC advertising in recent years since the FDA relaxed its regulatory rules on the matter in 1997. Dr. Kikano commented that while a well-informed patient is welcome, often there exists a disconnect between the information available to them and what might actually be the most appropriate treatment option for that individual. "It's a double-edged sword," he said. He cited statistics relative to aggregate spending on medications, and several studies showing the increased demand of physician's time in disseminating so much of this new data. On this point, he informed program listeners that the AMC/NOMA had recently written to the FDA (see sidebar) on the related issue of making drug missives to physicians more accessible and streamlined for the busy practitioner to sift through. Dr. Kikano concluded the interview session by reiterating that while so much information is now available to both patients and their physicians, together they can determine what medication, be it brand name or a more cost-effective generic, will work best. "At the end of the day, you have to trust your physician," he said. ■

As detailed in the March/April issue of the Cleveland Physician, The Academy of Medicine Cleveland/Northern Ohio Medical Association Board of Directors reviewed and adopted as policy recommendations regarding post-marketing drug safety issues—especially with regard to risk communications to prescribing physicians. We then submitted comments to the FDA's Center for Drug Evaluation and Research, outlining more specific suggestions in an effort to better serve the patient population, including changes to "Dear Doctor" letters and more accessible information on the agency Web site. Our letter may be read in its entirety via a prominent link at www.amcnoma.org

Smoke-Free Workplace Act Challenged

Second round of signature-gathering starts May 1

A coalition led by the Ohio Licensed Beverage Assoc. and RJ Reynolds Tobacco filed for a constitutional amendment April 7 that would allow smoking to continue in most businesses and erase the smoke-free policies already employed in 21 Ohio counties — a direct challenge to the initiated process by SmokeFreeOhio (with the support of the AMC/NOMA) to get a statewide ban on workplace smoking on the November ballot. The OLBA's proposal would amend Ohio's constitution while SmokeFreeOhio is instead working through the initiated statute process, thereby creating a new state law. According to the organization's co-chair Tracy Sabetta, "What Ohio needs is a fair smoke-free workplace policy that applies to all businesses statewide," she said. "With 21 smoke-free communities in Ohio and 13 states with a comprehensive law in place, why would Ohio willingly take a step backward and leave large portions of our citizens exposed to secondhand smoke in the workplace? Why in the world would we amend our state's Constitution to put a smoking area in a restaurant?"

SmokeFreeOhio submitted more than 167,000 signatures to the Secretary of State's office in November 2005. Once the petition was certified, the proposal was sent to the Ohio General Assembly in January 2006. The legislature then had four months to act on the proposal, with those four months expiring on May 2, 2006. Beginning May 3rd, SmokeFreeOhio will begin the second round of signature collection to place the Smoke-Free Workplace Act before voters this fall. ■



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Another Good Reason to Live in Cleveland, Ohio

By Arthur E. Varner, MD

ABSTRACT – American Academy of Allergy, Asthma and Immunology Meeting 2006

RATIONALE: Ragweed is the predominant pollen causing rhinitis symptoms in late summer in the Midwestern United States. For unknown reasons Cleveland, Ohio has the lowest ragweed pollen counts of any major city in the Midwest.

METHODS: Review of historical data and pollen counts from Cleveland and other major Midwestern cities.

RESULTS: From pollen surveys completed as early as the 1930s and from review of pollen counts available locally and regionally in recent years, Cleveland consistently has lower ragweed pollen counts than any other city in the Midwest. Cleveland's unique location by Lake Erie and northerly winds in the late summer may contribute along with other factors.

CONCLUSIONS: Cleveland, Ohio, has many positive attributes. One that has not been recognized is the low level of ragweed pollen compared to other Midwestern cities. Ragweed sufferers who enjoy living in the Midwest may find Cleveland an excellent place to live.

Spring in Cleveland comes and goes, but as the temperature gets above 50 degrees those with tree pollen allergies start to experience hayfever symptoms. Sneezing, itchy eyes and nose, congestion, cough, fatigue, and headaches can all be seen in those with hayfever. By the end of June the grass pollen season is

over, and until August 15, there is actually very little pollen in the air. Those experiencing symptoms at this time are generally allergic to dust mites and molds.

I myself had year-round allergies and eczema as a child. I was treated with immunotherapy for 2 years and had no problems until age 15, three years after moving to Columbus, Ohio. I would dread every August and September because my symptoms were very severe. For reasons that are unclear, I was never sent to an allergist by my family doctor and was just given steroid injections or pills. It worked well but I didn't realize the potential for side effects, nor did it make sense to wait and be miserable to get treated but do something to prevent the symptoms.

Eventually I found, by this time in medical school, that starting nasal steroid sprays in early August did a good job controlling my symptoms. In fact, over the years, and especially after moving to Cleveland 10 years ago, my symptoms are gone and I no longer require medications. This is despite still having a significantly positive skin test to ragweed.

Last year though, I discovered the real reason. As we were driving down to Columbus for Labor Day, I started sneezing as we passed Mansfield on I-71. The further south, the worse the symptoms till I had the full-blown eyes, nose, throat thing going — I really couldn't believe it. After a few miserable days, I was back in Cleveland and once again fine. I started researching the pollen data for Cleveland

and Midwest cities. I found an article published in 1928 that reported the first-ever pollen survey of major cities. Even in 1928, Cleveland had the lowest ragweed counts of any midwestern city. I then reviewed data from the last several years including pollen counts from Dayton, Indianapolis, Chicago, Kansas City, and Detroit. Almost every year over the last seven, Cleveland consistently has the weakest and shortest ragweed season.

The conclusion of all of this? I reported this paper at the recent American Academy of Allergy, Asthma, and Immunology meeting. The title: *Another Good Reason to Live in Cleveland, Ohio* for ragweed pollen sufferers, or at the least a good place to visit in August and September.

Dr. Varner is Board Certified in Allergy/Immunology and in private allergy practice with Allergy Diagnostic, with locations across the Northeastern Ohio region. Dr. Varner is in his second year coordinating the AMC/NOMA Pollen Line. Reports can be obtained daily by calling (216) 520-1050 or by going to the AMC/NOMA web site at www.amc-noma.org.

Editor's Note: The Pollen Line was a service originally initiated as a partnership with the Cleveland Health Museum and Lutheran Medical Center. This coming season will be the 47th year that the hotline has been in existence. The AMC/NOMA thanks Dr. Varner for his voluntary efforts. ■

COLLEAGUE'S CORNER



Dr. William H. Seitz, Jr., a specialist in the bone-lengthening technique callotasis, or distraction lengthening, was featured on the nationally broadcast program All Things Considered March 11. A complete audio transcript of the show can be heard at www.npr.com

Welcome 2006-2007 – AMC/NOMA Group Members

The AMC/NOMA gratefully acknowledges the following for their support of organized medicine in our region:

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DID YOU KNOW? That May 1st is the last day that the AMC/NOMA can accept dues from physicians for the 2006 year. If you have not yet paid your dues this will be YOUR LAST ISSUE OF THE CLEVELAND PHYSICIAN. Final dues billings were sent out at the end of April — if your office received a notice, please remember to pay your dues.

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