

## AMCNO Participates in Conference on Improving the Patient Experience

By: Lawrence T. Kent, M.D.

In November, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to sponsor a roundtable discussion at the Quality Institute of the Ohio Hospital Association's conference on *Improving the Patient Experience in Ohio Hospitals*, addressing the *Role of Medical Societies in Education and Engagement of Physicians* to improve HCAHPS scores in the region. The conference was co-sponsored by the Cleveland Clinic, University Hospitals Case Medical Center, and The MetroHealth System. Breakout sessions covered additional topics ranging from improving physician engagement to improving the HCAHPS instrument.



Dr. Lawrence Kent, AMCNO Immediate Past President (left), facilitated the AMCNO roundtable discussion at the patient experience event.

### The Origin of HCAHPS

The Hospital Consumer Assessment of Hospital Providers and Systems (HCAHPS) is a survey instrument designed to assess patient experiences during their hospital stays. Originally developed and validated by the Agency for Healthcare Research and Quality (AHRQ) for The Center for Medicare and Medicaid Service (CMS) in the early 2000s, HCAHPS was the first tool of its kind to create a set of common measures and national



standards for assessment of patient satisfaction. The HCAHPS survey consists of 27 questions covering eight "domains" of patient satisfaction. Each domain consists of two or three questions covering six core areas of a patient's experience with nurse communication, physician communication, staff responsiveness, pain management, medication reconciliation, and discharge

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## AMCNO Co-Sponsors Medical Malpractice Seminar

Over 85 physicians attended a session on December 6, 2012, when Roetzel & Andress, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and the Northeast Ohio Medical University co-sponsored, *Medical Malpractice Claims — The Impact of Being Sued*. This half-day seminar addressed risk management and medical-legal issues, including the lawsuit and trial process, the nuts and bolts of medical malpractice trial presentation, the False Claims Act (FCA), and the emotional and psychological impact of being sued on a healthcare provider.

Dr. James Sechler, M.D., AMCNO President kicked off the meeting with some opening comments and was followed by Anna Carulus of Roetzel & Andress, who outlined "The Anatomy of a Lawsuit," in which she provided the most important clues that a lawsuit could be filed. These include a litigious patient, adverse event,

a records request, and the 180-day letter with the records request. The 180-day letter is followed by a Summons & Complaint document, the official notification that a lawsuit is in the works. At this point, the first reaction might be to

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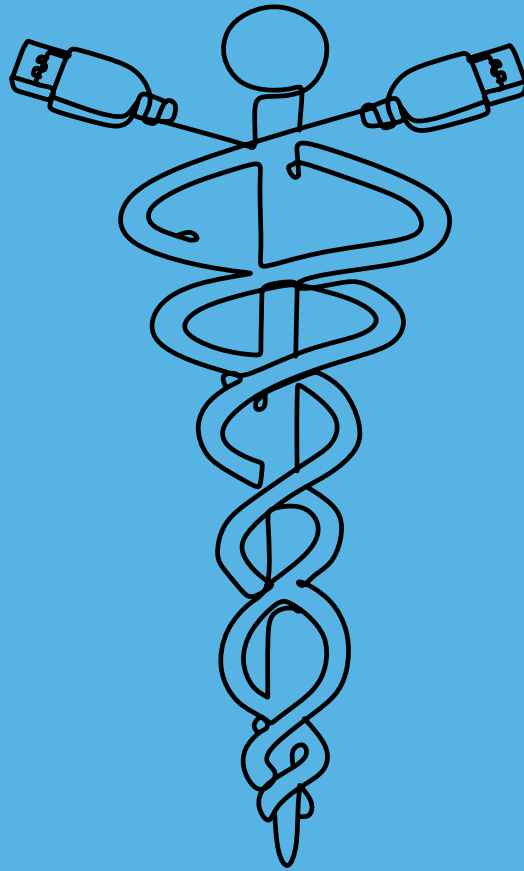
AMCNO President, Dr. James Sechler, provided the opening remarks at the Medical Malpractice Claims seminar.

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AMCNO  
6100 Oak Tree Blvd.  
Ste. 440  
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instructions. Questions for two additional domains — hospital quietness and cleanliness, and a global domain for overall hospital rating — were added at a later date (visit <http://www.hcahpsonline.org> for more details).

Since the passage of the Deficit Reduction Act in 2005 and the implementation of the Inpatient Prospective Payment System (IPPS) in 2007, HCAHPS surveys have been required and had to be administered in order for non-critical access hospitals to receive full Medicare payments. In 2010, Value Based Purchasing (VBP) was created as part of the Patient Protection and Affordable Care Act and when VBP was implemented in 2012 patient satisfaction became a significant issue for hospitals. VBP is a program designed to tie full hospital Medicare reimbursements to performance on a number of clinical and patient satisfaction measures. HCAHPS now makes up 30 percent of the total score of a hospital's VBP. The remaining 70 percent of VBP is made up of a hospital's performance on a number of clinical measures in major areas of hospital care such as pneumonia, congestive heart failure, myocardial infarction, surgery, and the list continues to grow.

The goal of VBP and HCAHPS is to provide objective, transparent, and meaningful comparisons of hospital performance; establish accountability; and incentivize improvement. The topic of patient satisfaction has increasingly received more attention because it has been shown to impact overall quality of care. Early data suggests that better patient satisfaction scores correlate with better quality of care outcome measures and perhaps this is related to better patient compliance and follow up with prescribed medical regimens. Also, lack of communication has been shown to be a significant factor in the cause of sentinel events (events that result in an unexpected outcome such as death or physical harm).

HCAHPS surveys are administered to a random sample of discharged patients from 48 hours to six weeks after discharge. The survey can be administered by mail, mail with telephone follow up, telephone, or an automated voice recognition program. The survey questions address various aspects of the patient hospital experience that are relevant to their care. Also, several of the questions are designed to correct for a mix of patients across hospitals. The surveys must be done each month of a given year and non-critical access hospitals must have at least 300 completed surveys per year. Eight "dimensions" (six summary measures, one summary measure of hospital cleanliness and quietness, and one global overall rating measure) are then reported for each hospital on the Hospital Compare website. Statistical reliability is increased by creating the

summary measures from HCAHPS questions across a number of domains.

The actual Patient Experience of Care Domain score is made up of two parts, the larger of which is improvement from a baseline period, or achievement, compared to a national median for each dimension (80 percent); and consistency, which sums up the hospital's lowest performing dimensions (20 percent). The final domain score makes up the 30 percent patient satisfaction component of VBP.

### Improving HCAHPS Scores

Hospitals have made considerable progress in meeting a number of the VBP clinical measures but improving HCAHPS has proved more difficult. This could be related to the multitude of factors affecting patient satisfaction as well as the high bar set by CMS for performance on these measures; since only a "top box" (highest satisfaction) patient response on each question in a domain is counted in the domain scoring. In addition, despite CMS statistical manipulations, a number of outside factors have also been shown to impact patient evaluation of hospital experiences. These include the age and education level of patients (older and less-educated patients tend to provide higher scores); hospital location (rural hospitals tended to score higher than urban hospitals); hospital size (large hospitals tend to have lower scores but small hospitals have more variability); hospital regional variability (highly specialized hospitals in one area tends to improve scores); and the type of survey method used (telephone surveys tend to yield better results than mail surveys). There should also be increased research on the effect of electronic medical records on patient satisfaction.

Finding ways to improve a patient's hospital experience is difficult because of the subjective nature of the measures, the variability and severity of patient illness and outcomes, and the increasing complexity of medical care. Many hospitals are using additional methods to assess patient satisfaction because they feel that HCAHPS does not adequately reflect the total patient hospital experience.

A number of Ohio hospitals have been able to show improvements on their HCAHPS scores. The *Improving the Patient Experience in Ohio Hospitals* conference featured a number of presentations offering proven techniques to help improve scores. Presenters stressed the need for top hospital leadership to be committed to improving patient quality of care as well as the patient experience. To accomplish a unified approach, all employees must work as a team. A positive patient experience is the result of receiving the right care at the right time and must be the goal of all hospital employees. Making patient care issues integral to all hospital practices was deemed absolutely critical to improve HCAHPS scores. The need for better

organization of data and data dashboards, and sharing the data widely within an institution, was also discussed.

### The Role of Physicians

Three of the 27 HCAHPS questions directly relate to patient satisfaction with physician care. However, physician ratings have a significant impact on the responses to the remaining survey questions. Conference breakout sessions discussed specific validated approaches to improve physician engagement and communication. Successful physician engagement strategies include benchmarking; making HCAHPS data transparent to all physicians and sharing it widely; providing data dashboards to make data meaningful and easy to understand; developing programs to identify and address disruptive physician behaviors; tying portions of physician compensation to HCAHPS performance; and suggesting that patient satisfaction surveys will become more, not less, widespread.

Physician-patient communication was also addressed and can be improved by a number of fairly simple listening and interviewing techniques. There is some data to support the four habits model of interviewing. *Invest* in the beginning — interviews should start with brief socialization (clear identification of physician name and role along with responsibilities); *Elicit* patient cooperation (ensure all patient concerns are identified up front); *Listen* (avoid interrupting patients); and *Invest* at the end (establish goals for the end of the hospital stay). One study showed that physicians, on average, interrupt patients 23 seconds into an interview. The interview itself should follow the acronym PEARLS — Partnership, [show] Empathy, Apologize when necessary, Respect and Legitimize patient concerns, and Support the patient at all times. These techniques have been shown not only to improve the patient experience but also to save time. The need for empathy and identification as well as addressing true patient concerns was mentioned as being overarching concepts.

Because of the effect on, and importance of, physicians to the HCAHPS process, and because similar survey instruments are scheduled for the outpatient setting, the AMCNO is taking a leadership position in this area. The AMCNO's presentation included results of an AMCNO survey developed to assess physician awareness, attitudes, and resistance to participation in improving patient satisfaction. The findings of the AMCNO survey suggest that physicians are aware of HCAHPS, that they believe improving patient satisfaction is important, and that they recognize that they have a significant effect on influencing a patient's hospital experiences. The survey responders also felt that educational meetings and regular email updates, and anonymous benchmarking and comparison to peers of HCAHPS scores would better encourage

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engagement. In addition, the responders are not opposed to having part of their compensation dependent on patient satisfaction survey performance. However, there was a fairly significant perception that the HCAHPS survey instrument itself is flawed and does not correctly measure patient satisfaction with physicians, rendering it more of a hospital — than a physician — problem. This might be particularly true in large hospitals where many physicians function as consultants. Efforts to engage physicians in this process may need to address these issues.

### Summary

Patient satisfaction surveys are here to stay. HCAHPS hospital data is already being presented online and will most likely be extended to the individual physician level in a couple of years. Organizations such as Consumer Reports are beginning to publicize this as well. Although valid criticisms of the subjective nature of the topic and the survey instrument themselves can be raised, evidence exists that indicates patient

satisfaction with health care providers, particularly physicians, influence overall quality of care. Physicians can be engaged in this process by benchmarking, sharing of physician HCAHPS data widely, use of better data analytic tools, and linking compensation, to some degree, to HCAHPS performance. Physician-patient communication can be enhanced by a number of simple interviewing principles and techniques which can be easily learned and have already been shown to improve HCAHPS scores. The general opinion at the conference indicated a need for hospitals and physicians to recognize the importance of patient satisfaction and continue to be proactive in order to ensure the best possible patient experience.

The AMCNO will continue to stay involved in this area. Future articles will highlight other hospital approaches to improving patient satisfaction. As patient satisfaction assessment moves to the outpatient arena, the AMCNO will keep our membership updated on this issue.

*Dr. Kent is the immediate past president of the AMCNO and serves on the AMCNO board of directors. He is also the AMCNO appointed representative to the Northeast Ohio Quality Collaborative. ■*

## Cuyahoga County Health Alliance Stress Management Workshop



*Dr. Françoise Adan, Medical Director of the Connor Integrative Medicine Network at Ahuja Medical Center, offers tips on how to reduce and relieve stress.*

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to participate in the latest Cuyahoga County Health Alliance which took place recently at the University Hospitals Ahuja Medical Center. The workshop was part of the Alliance initiative to address health improvement through regional collaboration and provided an opportunity for stakeholders to learn more about how to reduce and relieve stress in the workplace with a focus on health and wellness for their employees. Participants at the workshop included representatives and mayors from various municipalities, institutional partners, and others involved with the Health Alliance. Topics covered at this event included a discussion about

integrative medicine and guided imagery techniques that can be used to relieve stress, wellness and relaxation tips for employers, resources available in the community for stress management workshops, and a discussion about how one community is providing resources to their employees to cope with stress and wellness issues. Ms. Jennifer Scofield, representing the Office of the County Executive, provided the opening remarks and noted that they now have 22 communities involved in the health alliance initiative and workshops on health related topics will continue to be offered to the partners in this initiative. Presenters included Dr. Françoise Adan, Medical Director of the Connor Integrative Medicine Network, Ahuja Medical Center, who provided the group with some simple tips to help to reduce and relieve stress and she also guided the group through several imagery exercises. A panel discussion followed where presenters discussed wellness coaching and relaxation training techniques and where members of the health alliance could obtain assistance and resources to set up employee assistance programs. A mayor from the community also offered guidance on how her community had set up a health and wellness fair for their public employees. The AMCNO is an institutional partner participating in the Cuyahoga County Health Alliance and we will continue to provide updates on this initiative to our members. ■

## MedWorks Hosts October Healthcare Clinic



*MedWorks volunteers smile for the camera.*

Over 490 uninsured and underinsured Greater Clevelanders received health care, free of charge at MedWorks' October 27th Clinic held at the J. Glen Smith Health Center. A total of 1,100 medical services were provided, including lab work and prescriptions. MedWorks "Care + Connection" approach ensured that every patient also met with a social worker who provided referrals and linkages to community safety net providers for follow up care and other needed services.

The clinic was made possible thanks to the generosity of medical and lay volunteers who devoted their day to delivering free care to those in need. MedWorks volunteer and Academy of Medicine of Cleveland & Northern Ohio (AMCNO) past president, Dr. Laura David, led the women's health group in providing exams to 73 women. The AMCNO is a supporter of MedWorks and, in addition to serving on MedWorks board, Dr. David has volunteered countless hours of her time at every clinic since MedWorks inception. Dr. David is also a current member of the AMCNO board of directors.

MedWorks is a non-profit organization committed to improving access to healthcare for Ohio's uninsured and underinsured. MedWorks provides an innovative vehicle through which healthcare providers, corporate sponsors, and other volunteers can provide free healthcare, education and ancillary services to the medically underserved. Over 6,500 patients have received critical medical, vision, and dental care, as well as assistance in linking to a medical home, from MedWorks since 2009. To learn more about MedWorks or volunteer please visit their website at [www.medworksusa.org](http://www.medworksusa.org). ■



## Patient Protection And Affordable Care Act ("ACA")

### Post-Election ACA in the U.S. and Ohio

#### Introduction:

As many readers may be aware, on June 28, 2012, the U.S. Supreme Court upheld a significant portion of President Obama's Act Healthcare Law — The Patient Protection and Affordable Care Act ("ACA"). Following that decision, this Journal published an article addressing the ACA's anticipated impact on physicians. Although the previous article analyzed the potential pros and cons of the ACA, there remained a significant degree of uncertainty as to how the ACA would be implemented, whether it would be supported by state governments, and whether the November election cycle would result in a change of leadership, which could have potentially caused the ACA to be rescinded.

Since the re-election of President Obama, and since the Democrats have remained in control of the Senate, it is increasingly clear that the ACA is here to stay. Accordingly, this article, as part of a series of articles, will further address the changes most imminently expected as a result of the ACA, as well as the State of Ohio's handling of its decisions related to the implementation of the ACA.

#### National Implementation of ACA; Changes expected in 2013:

Healthcare providers and patients alike are continually watching the federal government for more detailed information concerning the implementation of the ACA. To date, many questions remain unanswered. In a recent interview, economist, Gail Wilensky, Ph.D., the former chairwoman of the Medicare Payment Advisory Commission, stated, "watch out for anyone who tells you, this is what your future will look like, because they can't possibly know." Dr. Wilensky provided this commentary at an annual meeting for the Advocacy for Healthy Partnerships conference wherein she further expressed frustration over the ACA, and the lack of detail as to how the law will be carried out and/or impact physicians. Dr. Wilensky stated, "two thousand pages of legislation wasn't enough to say anything about reforming how we pay physicians." These frustrations are no doubt likely shared by many readers of this article. For that reason, over the next several months, this Journal will attempt to provide updates concerning the implementation of the new law and its impact on the health care industry. In the meantime, the remainder of this article will focus on the most transparent changes we are likely to see in 2013.

On November 1, 2012, in compliance with the mandates set forth in the ACA, the Centers for Medicare and Medicaid Services issued a final rule regarding Medicaid reimbursements for primary care practitioners. Pursuant to the rule, effective January 1, 2013, Medicaid reimbursements will be brought on par with those of Medicare for primary care providers in 2013 and 2014. The federal government will pay 100% of the difference between Medicaid state plan payments and the applicable Medicare rate. The

increase will most directly impact family medicine physicians, general internists and pediatricians. The Secretary of Health and Human Services Kathleen Sebelius says, "by improving payments for primary care services, we are helping Medicaid patients get the care they need to stay healthy and treat small health problems before they become big ones." This change in law has also come with great support by entities such as the American Academy of Family Physicians.

Also in 2013, the ACA requires implementation of authority to allow "bundle payments." The ACA established a nationwide pilot program designed to encourage providers to work with other providers to coordinate and improve the quality of patient care. Bundle payments allow the delivery of a flat rate for an "episode of care" to providers, rather than the current system of individually billing Medicare for each service provided. As an example, in the instance of a surgical procedure, instead of submitting multiple claims for payment, from multiple providers, the entire care team could be compensated with a bundled payment. The goal is that this program incentivize health services to be provided more efficiently, while still maintaining quality of care.

There is also a "Sunshine Act" component to the ACA that is expected to have impact beginning in 2013. A final rule regarding this provision has been drafted, but not yet approved by the Office of Management and Budget. Without all details yet available, the purpose of the rule is to create new transparency requirements. This law will likely take effect starting in March 2013, and will require pharmaceutical companies to report any single payment/transfer of \$10 or more made to a physician. This is just one example of the requirements expected to be set forth in the final rule that seeks to create more transparency in financial relationships between health care providers and suppliers.

Another change coming in 2013 as a result of the ACA is the new Internal Revenue Service ("IRS") provision related to medical devices. According to a final rule issued in December 2012, the IRS will impose a "Device Tax" on the sale of any taxable medical device at a rate of 2.3%. The tax is effective as of January 1, 2013. The government's justification for this tax is that the durable medical equipment industry is one set to gain business as a result of the expansion of health care coverage under the ACA — and since demand is increasing, the costs associated with the tax will be offset by increases in product sales.

In addition to the several provisions/changes highlighted above, the other most notable changes coming in 2013 relate to the way in which state governments respond to the ACA.

#### Ohio's Response to the ACA:

There are two primary issues of focus relative to the Ohio government's implementation of the ACA. The issues include the handling of: 1) the

"insurance exchange" program, and 2) the optional expansion of Medicaid.

On the first issue, the federal government has extended its deadline until December 16, 2012, for states to decide if they will allow the insurance exchange program to be run by federal agencies, instead of state agencies. Ahead of this deadline, Ohio has already made its decision. Lieutenant Governor Mary Taylor announced in November, 2012, that Ohio plans to let the federal government run the new health insurance exchange program.

Healthcare markets, called exchanges, are designed to help people and small businesses find affordable care coverage. The exchanges will help low income Ohioans enroll in Medicaid, as well as to set rules for premiums and provide consumer protection guidelines. The markets are a key element of the health care law, where millions of individuals are expected to shop for coverage and find out if they are eligible for government subsidies or Medicaid. The law requires the federal government to build and operate the markets, if states do not.

For the federal administration, one of the most difficult decisions will be to decide how insurance policies must be designed, priced, and sold, starting next October, 2013, when open enrollment begins for the new online marketplaces, called exchanges. For example, the ACA allows insurers to alter their prices for people based on their age, family size, where they live, and tobacco use. The Department of Health and Human Services has to determine how insurers can go about setting prices relative to these demographics.

The second primary consideration for states, such as Ohio, is whether the state government will decide to "expand" its Medicaid program. Pursuant to the U.S. Supreme Court's ruling this summer, states that do not want to expand Medicaid eligibility up to 133% of the federal poverty guidelines, or about \$30,000 for a family of four, could opt out in 2014, without losing current Medicaid dollars. The federal government has not set a date in which the states must decide if they will expand their Medicaid program. Ohio has not yet made this decision. Ohio officials have indicated that a decision on whether to expand Medicaid eligibility is likely to coincide with the drafting of the state's biennium budget next spring.

A report released in November, 2012, by Kaiser Family Foundation estimates that if Ohio participates with implementation of the Medicaid expansion, it will reduce the number of uninsured in Ohio by 991,000, by 2022. Importantly, the federal government, pursuant to the ACA, would pick up 100% of the tab for the expansion until 2017. After that, however, federal funding decreases annually down to 90% in 2020 and beyond. State leaders have estimated that Ohio's

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## Patient Protection And Affordable Care Act ("ACA") (Continued from page 5)

share in 2017 and 2018 would be \$457 million to pay for the newly enrolled.

The expansion of Medicaid was designed to be a major part of President Obama's health care law, originally expected to account for half of the 32 million people who were to gain coverage under the ACA. Whether states, including Ohio, choose to expand the program, will have a significant outcome on the overall impact of the ACA.

In a statement made in June 2012, Governor Kasich said his administration is "very concerned that a sudden, dramatic increase in Medicaid spending could threaten Ohio's ability to pursue needed reforms in other areas." Although Ohio has not decided whether it will expand its program, many believe this statement is a clue that it will not.

### Conclusion:

In closing, although there still remains much uncertainty over the anticipated impact of the ACA, the federal government has issued several rules in recent months, which are starting to give

us a better picture of what to expect in the immediate future.

For further information regarding the ACA and/or issues that may be specific to your practice, please do not hesitate to contact David Valent, at Reminger Co., L.P.A., [dvalent@reminger.com](mailto:dvalent@reminger.com), with your questions or thoughts. Also, please feel free to contact the AMCNO editorial staff at [ebiddlestone@amcno.org](mailto:ebiddlestone@amcno.org) with your thoughts regarding specific issues of the ACA that you would like to see addressed in the series of articles this Journal intends to publish regarding the ACA. ■

## AMCNO Co-Sponsors Medical Malpractice Seminar

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contact the plaintiff (patient), the plaintiff attorney, other named doctors, subsequent treating doctors, or even the judge. According to Ms. Carulus, none of these ideas are viable options. A defendant does not have attorney-client privilege in any of these conversations. Anything said can be repeated during the litigation process. She advised that physicians should notify and provide documents to the insurance carrier or hospital law department and make sure that the attorney-client privilege is maintained at all times.

Ms. Carulus also advised against amending medical records at any time noting that any changes to existing medical records can be construed as an intention to "cover up wrongdoing" and may result in a punitive damage claim as well.

The judge can also make a significant difference in how the case is dealt with in the court system by establishing a schedule, setting dates and deadlines for discoveries, expert reports, the final pre-trial, settlement conferences, and the trial date, if necessary. Ms. Carulus also noted that trial preparation is of key importance and it behooves the defendant(s) to know the facts of the case. Working closely with the attorney, and providing full disclosure of the facts, can help the defendant anticipate all areas of questioning before it begins. Expert witnesses will also be deposed to establish the common standard of care, causation, and damages.

R. Mark Jones, representing Roetzel & Andress, cautioned physicians to be flexible and patient, however difficult it may be during the pre-trial period. Trial preparation includes putting all of the pieces together, developing a strategy, and creating a persuasive argument that focuses on the facts, explain the practice of medicine, creates proper perception among jurors and overcomes sympathy. Before the trial, lawyers will try to limit the evidence, as well as facts and issues of fault. Jurors will be selected and a civil case requires eight jurors; and only six of the eight needs to agree with the case in order for

penalties to occur. The civil case is simply plaintiff vs. defendant, with the objective being not to remove the defendant's freedom but to provide financial "recovery" to the "victim." The burden of proof is the preponderance of evidence rather than the "beyond a reasonable doubt" required in a criminal case. Criminal cases move much faster but require a unanimous jury and the defendant is facing the state/prosecutors office rather than the "victim."

### How to Deal with a Cross Examination

Roger Dodd, of Dodd Law shared his expertise on cross examination. Mr. Dodd pointed out that logic and intuitive thinking don't always work in the courtroom. He advises that defendants disassociate from what is familiar to them and to keep in mind that even lawyers are insecure in the courtroom. According to Mr. Dodd, the doctor factors into only 30 percent of the case but makes up the most important part. He noted that sixty-five percent of the case is comprised of the events occurring in the courtroom and five percent involves the defense attorney. Mr. Dodd noted that jurors tend to base their votes on moral belief, not mere facts. Facts that are bogged down with detail are not often remembered, and he noted that convincing, not facts, leads to certainty so putting testimony into the form of a story will help teach the case to reluctant listeners.

He also noted that cross examination is often one of the most stressful components of a trial. In all cases, the facts trump all so always work with just the facts (no conjecture) and assume no one understands what you are about to say and explain everything in as simple terms as possible. In addition, rely on the attorney to determine which facts are best to share, stay focused on the theory, don't volunteer information and finally, remember; the odds are most likely on the physician's side.

Ms. Stacy Ragon Delgros, from Roetzel discussed the apology statute noting that this statute protects any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that relates to the discomfort, pain, suffering, injury, or death of the alleged victim as the result

of the unanticipated outcome of medical care. She noted that under Ohio law a physician may speak with a patient and/or a patient's family members and express his/her heartfelt sympathy for their pain following a negative outcome without risk of that expression of sympathy being used against him in court, but remember that this statute does not include making a statement that something was your "fault."

### The Emotional and Physiological Impact of Being Sued

Dr. Gregory Collins of the Cleveland Clinic Foundation; and Dr. Martha Hackett, participated on a panel discussion with Dr. Jason Kolb, Alliance Community Hospital; Stacy Ragon Delgros and Beverly Sanchacz, from Roetzel & Andress. The panel discussed the emotional and physiological impacts often suffered by physicians embroiled in long-term lawsuits. Dr. Collins noted that the most common emotional and physical impacts of a lawsuit on a person, include depression, anger, intense worry, and distraction. According to Dr. Collins, 16 percent of doctors experience some type of physical illness, seven percent abuse alcohol, and less than one percent abuse drugs as a result of the stress of a long-term lawsuit. In addition, fear and anxiety are frequently experienced along with longer workdays, avoidance, and an obsession over the incident, and/or the practice of defensive medicine. The panel did point out that it is unproductive to believe oneself to have failed or to accept too much blame for an unexpected outcome noting that it is advisable to manage emotions by working closely with one's defense counsel and to be actively involved in the defense process.

The AMCNO would like to thank Roetzel & Andress and the Northeast Ohio Medical University for co-sponsoring this important seminar. (Editor's Note: The session also included a presentation on "Strategies in False Claims Act (FCA) Cases and Compliance Techniques" — this topic was already covered in a previous issue of the Northern Ohio Physician in an article prepared by R. Mark Jones from Roetzel & Andress. To view the article go to our website at [www.amcno.org](http://www.amcno.org) and search on "False Claims.") ■

## **Administrative and Statehouse Activity**

During the last month of 2012, there was a flurry of activity in the Ohio legislature as the lame duck session wound down. In addition, the administrative offices continue to evaluate and review issues related to the Affordable Care Act that could have a huge impact on the entire state. Also, during the first six months of 2013, the legislature and the administration will be focusing on the state budget.

## **Medicaid Expansion**

Originally, under the Affordable Care Act (ACA), all states would have had to expand their Medicaid programs to all people earning up to 133 percent of the federal poverty level. States that did not expand their Medicaid program would have been subject to penalties in that they would not be eligible for their federal Medicaid matching funds — funds that the states count on to help fund their Medicaid programs. When the Supreme Court ruled on the legality of the federal healthcare reform law that the Medicaid expansion was optional, the entire discussion in every state changed. Since the states no longer had to be concerned about losing federal matching funds they could now determine whether or not they wanted to expand Medicaid or not.

In December 2012, the federal government informed states that a partial expansion of Medicaid eligibility is not an option it will support financially. The possibility of expanding eligibility to 100% of the federal poverty level (FPL), instead of the 133% called for in the Affordable Care Act, was among the options Ohio officials have been investigating. Health and Human Services Secretary Kathleen Sebelius sent a guidance document to all state governors that indicates the federal government will not provide 100% matching funds in the first three years of the Medicaid expansion if that eligibility change is less than 133% FPL. However, if a state that declines to fully expand coverage under the law would like to do a demonstration project, which includes partial expansion, the federal government would consider the proposal to the extent it furthers the purposes of the program, subject to the regular federal matching rate.

At press time, Ohio Governor Kasich had not yet determined whether or not the Medicaid program would move forward in Ohio and the Kasich administration is expected to announce as part of its budget proposal whether the state will follow through with the Affordable

Care Act's expansion of Medicaid coverage. Ohio Medicaid has been reviewing the numbers to determine how much the expansion could cost the state of Ohio on top of the people already eligible but not enrolled in Medicaid who are expected to sign on via the "woodwork effect." Officials have mentioned the possibility of going half way on the expansion and raising eligibility to 100% of the federal poverty level because the ACA-required health exchange will allow individuals to buy insurance if they are between 100% and 400% of the FPL.

## **Federal Health Insurance Exchange**

The ACA includes a number of significant changes to America's health care system, including a requirement that every American have health care coverage or possibly face a tax penalty and new taxes and penalties on employers that don't provide employees with specific types of health coverage. The ACA also mandates the creation of health insurance exchanges in every state, through which individuals and small business owners can purchase qualified coverage. The ACA allows three options to administer a health insurance exchange: states can run the exchange themselves, choose not to run it and leave it to the federal government, or leave it to the federal government while retaining the right to regulate health insurance and control eligibility decisions for their Medicaid programs. Exchanges must be in place by January 1, 2014.

Governor Kasich has notified the U.S. Department of Health and Human Services that Ohio will not administer an exchange but will retain regulatory control over health insurance plans offered through a federally-operated exchange as well as retain the authority to determine Medicaid eligibility. In a letter to Gary Cohen, the director of Department of Health and Human Services' Center for Consumer Information and Insurance Oversight, Governor Kasich announced Ohio's intent to implement a hybrid exchange. Governor Kasich also noted that although the state will go with a federally run model, it has decided to continue regulating its insurance market through ODI and determining Medicaid and Children's Health Insurance Plan eligibility for residents through Ohio's Medicaid Director.

## **CMS Approves Medicare-Medicaid Duals Project**

The federal government has approved Ohio's demonstration project to coordinate care for

individuals eligible for both Medicare and Medicaid, which is expected to save \$243 million in Medicaid costs over three years. The Centers for Medicare and Medicaid Services' agreement with the administration makes Ohio the third state to solidify a pact for use of a managed care approach for the dually eligible population.

The 29-county, three-year Integrated Care Delivery System (ICDS) demonstration project will reach about 114,000 of the 180,000 eligible individuals and allow the state to identify and incentivize techniques for improving care for the dually eligible population. Long-term services and supports, behavioral-health services and physical-health services are part of the program. In August of this year, Ohio Medicaid selected five health plans to participate in the seven regions of the ICDS project. Enrollment in the plans has again been delayed. Originally slated for February 2013, the state pushed back its timeline to April to meet a federal request that the enrollment begin at the start of a quarter. The final agreement sets voluntary enrollment at Sept. 1, 2013. Once voluntary enrollment has been implemented, depending on the region, eligible Ohioans who have not chosen a plan will be assigned to one with the option to opt-out of the Medicare side or select an alternative ICDS plan.

## **Leadership Chosen for the Next General Assembly**

Following the recent election, House and Senate Republicans continue to hold strong majorities in both chambers. Members of leadership will assume their roles in early January, 2013.

Senator Keith Faber (R-Celina) was unanimously elected to serve as Senate President for the 130th General Assembly, replacing current President Tom Niehaus (R-Cincinnati) who is unable to run for reelection due to term limits. Senator Faber was elected to the Ohio Senate in 2007, having previously served three terms in the Ohio House. Senator Chris Widener (R-Springfield) was elected president pro tempore, Senator Tom Patton (R-Strongsville) was reelected as majority floor leader.

Senate Democrats voted unanimously to keep Senator Eric Kearney in the top spot as minority leader. Members of the caucus also voted to keep its remaining leadership team intact for next session, which includes: Senator

*(Continued on page 8)*



(Continued from page 7)

Joe Schiavoni (D-Youngstown), assistant minority leader; Senator Nina Turner (D-Cleveland), minority whip; and Senator Edna Brown (D-Toledo), assistant minority whip.

House Republicans voted to retain a majority of their leadership team, unanimously electing William G. Batchelder (R-Medina) as speaker of the House. Representative Matt Huffman (R-Lima) was elected speaker pro tempore, Representative Barbara Sears (R-Sylvania) will serve as majority floor leader, Representative John Adams (R-Sidney) was voted assistant majority floor leader, Representative Cheryl Grossman (R-Grove City) will serve as majority whip, and Representative Jim Buchy (R-Greenville) was elected assistant majority whip.

House Democrats voted to reelect the current caucus leadership team for the 130th General Assembly, voting to keep Representative Armond Budish (D-Beachwood) as minority leader. Members also voted to retain Representative Matt Sczollosi (D-Oregon) as assistant minority leader; Representative Tracy Heard (D-Columbus) as minority whip and Representative Debbie Phillips (D-Athens) as assistant minority whip.

### **Three Bills Supported by the AMCNO Signed by Governor Kasich, Other Legislative Activity**

Several bills that were strongly supported by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) are heading to Governor Kasich for his signature.

House Bill 334 – Pseudophedrine Sales Tracking – would add Ohio to a multi-state, real-time, stop-sale system known as the called the National Precursor Log Exchange (NPLEx) – which monitors purchases and attempted purchases of products containing pseudoephedrine (PSE). Dr. Terry Johnson, a physician in the Ohio House and a sponsor of the bill, has indicated that the proposal would help law enforcement agencies catch illegal methamphetamine makers.

HB 143 – Youth Sports Injuries – House members also voted 94-0 to concur with Senate amendments to legislation that would require youth sports coaches to remove athletes from play if they suspect a player may have a concussion. HB 143 would also prohibit coaches from allowing the athlete to return to games or practice until they get approval from

medical personnel and increase training requirements to recognize concussions.

Senate Bill 301 – Controlled Substances – this bill would enhance the enforcement powers of certain health care professional licensing boards, regulation of pain management clinics, limits on prescriber-furnished controlled substances, and classifications of certain controlled substances. The law is meant to tighten up some regulations that had been enacted in the last General Assembly in HB 93. For example, at this time the Medical Board can currently only inspect physicians, but not the pain management clinics themselves and this new law will allow the SMBO to conduct these inspections. The law will also allow doctors to check the Ohio Automated Rx Reporting System before accepting a patient in an effort to prevent drug addicts from “doctor shopping.” This bill was strongly supported by the AMCNO as well.

Also headed to the Governor for his signature is House Bill 294 – Physician Assistants – a bill that will modify the laws governing physician assistants. The bill authorizes a PA to perform several medical services including fit, insert, or remove birth control devices, issue a DNR order in certain circumstances with physician supervision and in specified locations only, insert or remove chest tubes, prescribe or make referrals for physical therapy and order or make referrals for occupational therapy. This bill will also require the SMBO to promulgate new rules for PAs.

Unfortunately, HB 421 – Physician Immunity – a bill that would have amended sections of current law that provide immunity from violation of a patient’s privacy rights, passed out of the House Criminal Justice Committee but never made it to the floor of the House for a vote. The AMCNO plans to reintroduce this legislation in 2013.

Other bills that were introduced in lame duck HB 607 – Health ID and HB 609 - Telehealth Services will more than likely be reintroduced in the next General Assembly. HB 609 would mandate that Medicaid cover certain telehealth medical services in an amount not to exceed that which would pertain to a face-to-face visit. The bill would also authorize – but not mandate – other health care insurers to offer coverage for telehealth services. The AMCNO supports this concept and we have asked to be involved in any interested party meetings on the legislation. HB 607 – Health I.D. – would

require certain health care professionals to wear, when providing direct patient care, an identification card, badge, or similar device that includes a photograph of the professional, and specifies the license held by the professional and to make certain changes regarding advertising for health care services. The AMCNO strongly supports this concept and we asked to be involved in interested party meetings on this legislation as well.

### **AMCNO Election Results**

The AMCNO Northern Ohio Political Action Committee (NOMPAC) endorsed several Northern Ohio candidates running for the Ohio Senate and the Ohio House in the 2012 election. All of the NOMPAC-endorsed candidates from Northern Ohio, with one exception, were elected. The NOMPAC also made recommendations in the 8th District Court of Appeals and the Cuyahoga County Common Pleas Judicial races. Several of the NOMPAC-recommended judicial candidates were elected to the courts. The complete AMCNO Election Overview is included as an insert in this issue of the Northern Ohio Physician.

The AMCNO monitors all health care related legislation under review at the state legislature. For more information on legislative matters members may contact the AMCNO offices at (216) 520-1000. ■

## NORTHERN OHIO PHYSICIAN

### **THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO**

6100 Oak Tree Blvd., Suite 440  
Cleveland, OH 44131-2352  
Phone: (216) 520-1000 • Fax: (216) 520-0999

#### **STAFF Executive Editor, Elayne R. Biddlestone**

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# Save The Date

2013

## Medical/Legal Summit

April 12 & 13, 2013

Cleveland's first Medical/Legal Summit will be co-sponsored by the Cleveland Metropolitan Bar Association, Academy of Medicine Education Foundation, and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Chair: Kim F. Bixenstine, *Vice President & Deputy General Counsel, University Hospitals*

Vice Chair: Matt Donnelly, *Deputy Chief Legal Officer, Cleveland Clinic*

It is intended to bring together doctors, lawyers, health care professionals and others who work in allied professions in Northeast Ohio for education, lively discussion and opportunities to socialize.

For more information, call the CMBA at (216) 696-2404 or AMCNO at (216) 520-1000.

### SUMMIT DETAILS

April 12 – 1.5 CLE hours  
Plenary address and Q&A session: 4–5:30 p.m.  
followed by networking reception

April 13 – 4.00 CLE hours  
Continental Breakfast: 7–8 a.m.  
Program: 8 a.m.–12:30 p.m.

Location  
Cleveland Marshall College of Law  
1801 Euclid Avenue

Keynote Speaker  
Dr. Ezekiel “Zeke” Emanuel

Early Registration rate before March 1  
\$75 CMBA members, AMCNO members and  
employees of health systems  
\$125 Non-Members

After March 1, add \$50 to listed price

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This activity has been approved for AMA PRA  
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#### Sessions

- Apologies and Disclosures of Adverse Events:  
What to Say When Something Bad Happens to  
a Patient?
- Debate on End of Life and Other Medical, Legal  
and Ethical Issues

#### Break out Session Options (select two)

- Pain Management in the Face of the  
Prescription Drug Abuse Epidemic
- A Frank Conversation with Government  
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- Cyber Security and HIPAA Breaches
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## CHAP Celebrates County-Wide Access Plan

The Cuyahoga Health Access Partnership (CHAP) welcomed the community to the Cuyahoga Community College Institutional Advancement Center on October 25, 2012 to celebrate the launch of its signature initiative, the Access Plan. This event highlighted the progress CHAP made in its first full year of operations addressing the needs of the uninsured adult population in Cuyahoga County. Keynote Speaker, Health Policy Institute of Ohio President Amy Rohling McGee, highlighted the significant decisions still pending in Ohio while outlining the role for community health advocates and unique community collaborations, such as CHAP, in the future.

### CHAP History

In 2009, CHAP was established as a new organization focused on improving health access for the low-income, uninsured population in Cuyahoga County. The new CHAP Board of Directors secured funds from local hospitals, payers, government, and foundations to begin CHAP's operations. Throughout 2010, CHAP's Board of Directors developed and refined The Access Plan, a specialty referral network for uninsured adults, and customized the web-based financial eligibility software package to standardize eligibility interviews and enrollment across provider partner organizations.

### The First Year

In 2011, the Board hired Sarah Hackenbracht as the new Executive Director. With a staff of three and a network of partner representatives, CHAP launched electronic Access Plan enrollment in April 2012. Today, nearly 900 Cuyahoga County residents have received coordinated primary and specialty care as a result of their CHAP membership.

The current CHAP member population paints a picture of the uninsured population of Cuyahoga County and illustrates the significant need in our community. The majority of members are between the ages of 41 and 60. Sixty percent have incomes under \$10,000 per year, and only 22% of members make over \$15,000 a year. Sixty-four percent of CHAP members have incomes that are at or below 100% of the Federal Poverty Level.

Because CHAP developed its system with input from community health center and hospital partners, the requirements for CHAP mirror the Hospital Care Assurance Program (HCAP) requirements, which allows the CHAP application to serve as the HCAP application in Cuyahoga County. In 2012, CHAP received support from the Ohio Hospital Association and Ohio Department of Job and Family Services for the dual-use HCAP/CHAP application to make the process of rating even easier for patients and financial counselors. CHAP specialty care locations have provided over 780 specialty care referrals to CHAP



*Amy Rohling McGee, President of the Health Policy Institute of Ohio (HPIO) presents her comments at the CHAP annual meeting.*

members, which have steadily increased in number as the year progressed. Patients received several referrals for various needs, including cardiology, neurology and dermatology.

As CHAP has grown, members can be found in every zip code within Cuyahoga County. The proximity of a provider care clinic makes a great deal of difference to the lives of uninsured residents living in that area, something CHAP sees as an important part of future provider expansion.

### The Continued Need for CHAP

The need for CHAP in Cuyahoga County will continue to exist even after health care reform is fully implemented in 2014. With an uninsured adult population under 400% of the Federal Poverty Level nearing 147,000 residents, Cuyahoga County ranks 53rd in the Ohio for overall health factors, but 7th in clinical care. These numbers illustrate that the infrastructure for quality care exists in Cuyahoga County, but access for our most vulnerable citizens is lacking.

In 2014, individuals with income between 0 – 138% of Federal Poverty Level will qualify for the planned Medicaid Expansion, with the remaining population covered by proposed Health Insurance Exchanges. A number of decisions regarding the Medicaid Expansion and benefits available through the Health Insurance Exchange are still pending in the

State of Ohio, which leads CHAP to believe it will continue to be a critical part of the safety net to prevent uninsured adults from falling through cracks of these support programs.

Some disenfranchised adults will require CHAP's services to help navigate a changing and complex environment. The newly unemployed and the working poor, whose incomes make them ineligible for government assistance while struggling to make ends meet, will need the services and simplicity CHAP provides through the Access Plan. Supporting existing primary care and specialty care capacity is essential to connecting patients with a health home, and CHAP seeks to expand its provider network to provide additional access points throughout Cuyahoga County.

The future expansion of CHAP's provider network is directly linked to CHAP's strategic plan, which was approved by the Board of Directors in 2012 and will guide the organization as it seeks to fulfill its mission — to transform Cuyahoga County into a model of health and wellness by connecting individuals to access to care in 2013 and 2014. For additional information about CHAP, please visit [www.cuyahogahealthaccess.org](http://www.cuyahogahealthaccess.org) or call 1-888-929-CHAP (2427) to discuss a provider partnership opportunity.

### Founding Partners

Academy of Medicine of Cleveland & Northern Ohio  
Care Alliance Health Center  
CareSource  
City of Cleveland  
Cleveland Clinic  
Cuyahoga County  
Free Clinic of Greater Cleveland  
Kaiser Permanente  
MetroHealth System  
Neighborhood Family Practice  
Northeast Ohio Neighborhood Health Services  
North Coast Health Ministry  
Saint Luke's Foundation  
Sisters of Charity Health System  
University Hospitals ■

## Ohio Health Literacy Conference: Understand. Act. Live.

*Karen Komondor, RN, CCRN*

More than 150 health care providers, adult literacy providers, patient educators and policymakers from across Ohio attended the inaugural Ohio Health Literacy Conference held on October 26th at the Renaissance Cleveland Hotel.

Hosted by St. Vincent Charity Medical Center and Project Learn, the conference was the culmination of a yearlong series of workshops aimed at increasing awareness of the silent epidemic known as low health literacy.

Conference committee partners included the Academy of Medicine Cleveland & Northern Ohio, AIDS Taskforce, Better Health Greater Cleveland, Case Western Reserve University, City of Cleveland Department of Public Health, Cuyahoga County Board of Health, MetroHealth and the Visiting Nurse Association of Ohio.

### Conference recap

Attendees took home a robust understanding of how health literacy — the ability for people to understand health-related information and make informed decisions — impacts health reform, chronic disease management, and health care quality, safety and cost. And even more important, they took home a mandate for action. Councilman Joseph Cimperman opened the day with passionate support of the cause of health literacy, stating that there is, “No greater work being done in the city of Cleveland than the work of helping us understand one another.” He told the gathering that the work of health literacy can improve the health of all Clevelanders.

The opening presentation: “Health Literacy: What is it, What to do about it, Why is it important?” provided information on the scope and implications of the health literacy problem, including the fact that only one-third of adults are health literate. Strategies and techniques such as “Ask me three questions,” were offered as ways to help increase clear communication and patient understanding.

Program Officers Telange Thomas from the Sisters of Charity Foundation and Heather Torok, from Saint Luke’s Foundation described how grant funding supports health literacy initiatives. Grantees from the Visiting Nurse Association of Ohio, St. Vincent Charity Medical Center, and the Cuyahoga County Board of Health then offered concrete examples of how to implement and sustain health literacy programs at their organizations.

Christina Cordero, PhD, MPH, an associate project director at the Joint Commission, talked about how to apply new Joint Commission standards for patient-centered communication in the hospital setting. These standards include identifying and addressing communication needs, providing language services, providing information that patients can understand, and encouraging patient participation in care decisions.

The keynote address: “The National Action Plan as a Tool for Health Literacy Progress in Ohio,” was presented by Cynthia Baur, Ph.D., U.S. Department of Health and Human Services, Centers for Disease Control. In May 2010, the U.S. Department of Health and Human Services released its National Action Plan to Improve Health Literacy. Its goal: to narrow the gap between consumer’s health literacy skills and the communication demands of our health care system. That gap can be expensive.

Nationally, it is estimated that low health literacy costs \$106 to \$238 billion each year. That’s because low health literacy leads to increased frequency of hospitalizations, improper emergency room use, improper medication use, inappropriate use (or no use) of health care services, poor self-management of chronic disease, and inadequate response in emergency situations. It was less than 10 years ago that health literacy was first measured on a national scale. The results revealed that only

12 percent of Americans are proficient in health literacy. We learned that health literacy isn’t just an issue that affects people with limited English or low literacy skills; 88 percent of us are challenged by the health care system. And with consequences such as medical errors, prescription drug misuse and wasted dollars throughout the health care system, we can’t afford to ignore this issue.

With the tools provided at this conference, clinicians and organizational leaders can create action plans to help their patients better understand health information—and ultimately, improve health outcomes.

### What’s next?

The emphasis on clear communication is going to continue and expand as healthcare organizations fully implement the Affordable Care Act. That’s why St. Vincent Charity Medical Center and Project Learn are committed to continuing to advocate for health literacy.

We have shared the presentations from the Ohio Health Literacy Conference on our website. The PDFs are available for download at [www.stvincentcharity.com/OHLC](http://www.stvincentcharity.com/OHLC). We are also in the final stages for implementing a blog platform on our pages to help continue the conversation.

Finally, we are in the early stages of planning for next year’s conference and beyond. Recognizing the importance of partnerships, we will be seeking advocates across the state to help take the message of health literacy beyond our region. Together, we will begin the groundwork of building a statewide collaborative in support of health literacy.

*Karen Komondor is director of education and the Health Literacy Institute at St. Vincent Charity Medical Center.*



*Christine Cordero, the featured speaker from the Joint Commission, addresses the audience on patient-centered communications in the hospital setting.*



## State Medical Board Budget Process Continues

As reported previously by the AMCNO, the State Medical Board of Ohio (SMBO) biennial budget request submitted on September 17, 2012, included a request for a fee increase for M.D., D.O., and D.P.M. licenses. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and other medical associations sent letters indicating their members' opposition to the proposed fee increases. The AMCNO raised concerns that we had not been provided with sufficient need for the fee increase or a description of additional programs or services that would be funded with the new revenue. Concerns were also raised about the Board's fiscal accountability due to the fact that an annual report has not been generated since 2009.

As a result of these concerns, the SMBO has reevaluated their budget proposal and has made some modifications. These modifications will be submitted to the Office of Budget and Management before the end of the year and should be available to review in the near future. This budget proposal is predicated on promoting Board fiscal accountability and establishing a new way of operating for the next biennium. Through the FY 14/15 operating budget, the Board seeks to streamline its operations in a manner that provides for more expeditious delivery of services to applicants/license holders, reduces steps in the public complaint process; and refocuses resources on the core functions of the agency. The SMBO latest budget submission also includes fee increases for physician licensure.

In addition to a physician licensure fee increase, the SMBO plans to enhance their accountability and focus on core functions, streamline processes and increase productivity through audit processes, and identify any non-essential functions and positions; offer expedited licensure for individuals holding a medical license in another state (at a yet to be determined additional fee and this will require legislative change); review existing and new revenue sources including exploring the implementation of a proposal that would require licensees or applicants who are found to have violated the Medical Practices Act; to compensate the Board for a portion of the investigative costs involved in their case (process to be determined – this would require legislative change).

**Under the latest SMBO budget proposal there would be no change in the initial physician application fee, however, other physician licensure fees would be increased as follows:**

- A \$50 increase is recommended for the two year renewal (\$25 per year).
- An increase of \$95 is recommended for reinstatements (late renewals).
- An increase of \$195 is recommended for restoration applications (renewal after two years).

- No change is recommended for the other physician licensing fees: training certificates, training certificate renewal, duplicate certificates and wallet cards and licensure verification for other states.

The SMBO is also planning on pursuing a proposal for non-disciplinary fines for CME violations (this would require legislative change) as well as looking to outside sources to fund SMBO educational programs. The SMBO is also in the process of conducting a search for a new executive director and the AMCNO has posted this information as well as the SBMO draft budget proposal and physician licensure fee information on our website at [www.amcno.org](http://www.amcno.org) under the State Medical Board tab.

The SMBO also plans to provide regular communications to their licensees about this issue as well as other issues of importance to physicians and other healthcare providers in the state. In addition, the SMBO has released a FY 2011/2012 Annual Report which is now available on the SMBO website.

The AMCNO was pleased to learn that the SMBO plans to review their internal processes in order to improve their efficiency which we believe may result in reducing costs. The AMCNO board of directors met in December and agreed that it is appropriate for the State Medical Board of Ohio to review their internal functions and consider options for streamlining their processes and reducing their costs in order to meet their budget needs and we support the SMBO in these efforts. The AMCNO board also agreed to support the SMBO in their decision to review additional internal process changes and other areas of their budget in lieu of imposing additional licensure fees or monetary penalties upon physicians at this time.

The AMCNO board plans to continue to monitor this issue and provide an opinion regarding this and other budget proposals related to this matter as well as work with the state medical association, when feasible, as this budget process continues in 2013. ■



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## Save the Date

The Academy of Medicine of Cleveland & Northern Ohio Membership Committee cordially invites physician members, residents, medical students and spouses to attend our 2013 wine tasting experience. This is the perfect opportunity for you to mingle with your colleagues.

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## Ohio Supreme Court Rules on Statute of Repose

Erica M. James, MD, Esq., Susan Audey, Esq., Tucker Ellis LLP

In a flurry of end-of-the-year decisions, the Supreme Court of Ohio handed the medical community a major victory when it decided *Ruther v. Kaiser* and reversed the decision of the Twelfth District Court of Appeals that, if followed, would have allowed medical malpractice claims to be brought decades after the alleged malpractice occurred.

### The medical malpractice statute of repose

With some exceptions, the medical malpractice statute of repose, R.C. 2305.113(C), provides an outside time limit for potential liability. Distinct from the one-year statute of limitations for bringing a medical claim, the statute of repose operates to prevent plaintiffs from bringing medical malpractice claims based on underlying acts that occurred more than four years earlier. Claims made on behalf of minors and the mentally incompetent are excepted from the statute, as are claims based on alleged malpractice discovered between the third and fourth year after the alleged malpractice and those involving the discovery of foreign objects left in the body.

### The appellate decision

The underlying case involved acts of alleged malpractice that occurred in the 1990s and allegedly caused a patient's death in 2009. *Ruther v. Kaiser*, 12th Dist. No. CA2010-07-066, 2011-Ohio-1723. Timothy Ruther, while a patient of Dr. Kaiser, had lab work done in 1995, 1997, and 1998 that showed significantly elevated liver enzymes. Dr. Kaiser's office did not notify Ruther of these results. In December 2008 — after he had stopped being treated by Dr. Kaiser — Ruther was diagnosed with hepatitis C and liver cancer. In the lawsuit against Dr. Kaiser that followed, Ruther alleged that it was not until the time of his 2008 diagnoses that he became aware of his abnormal lab tests from the 1990s. Ruther died approximately one month later, and his claim was continued by his wife.

Despite falling squarely within the four-year statute of repose, the trial court refused to apply the statute and instead found it unconstitutional as applied to Ruther's medical claim. The Twelfth District Court of Appeals affirmed.

In finding the statute unconstitutional, both lower courts relied on the what is commonly referred to as the right-to-remedy or open-courts provision of the Ohio Constitution. 38. This provision provides that "[a]ll courts shall be open, and every person, for an injury done him in his \* \* \* person \* \* \* shall have remedy by due course of law \* \* \*." Article I, Section 16 of the Ohio Constitution. Giving short shrift to the due-course-of-law clause of this provision, the lower courts simply relied on an earlier Supreme Court case — *Hardy v. VerMeulen*, 32 Ohio St.3d 45 (1987) — which had construed a different version of the statute

of repose and found it to be unconstitutional because it denied a remedy to plaintiffs who were not able to discover that they were injured within four years. Despite acknowledged differences between the two versions of the statute, the lower courts relied on *Hardy* and said the present version of the statute is also unconstitutional.

### The Ohio Supreme Court reverses

The Supreme Court granted review and reversed. In doing so, it emphasized the due-course-of-law aspect of the right-to-remedy provision and made clear that this provision "does not prevent the General Assembly from defining a cause of action." *Ruther v. Kaiser*, Slip Opinion No. 2012-Ohio-5686. The General Assembly had every right and authority then "to determine what causes of action the law will recognize," and it could likewise "alter the common law by abolishing the action, by defining the action, or by placing a time limit after which an injury is no longer a legal injury." If it did not have this authority, "medical providers are left with the possibility of unlimited liability indefinitely."

The Court noted strong policy reasons for upholding the statute of repose as enacted: Just as a plaintiff is entitled to a meaningful time and opportunity to pursue a claim, a defendant is 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.

But even though strong public policy supported the legislation and the Court found no constitutional infirmities, the Court was not finished. It reexamined *Hardy* and overruled it. Relied on repeatedly by plaintiffs as support of the statute's unconstitutionality, the Court found the analysis in *Hardy* fatally flawed and "wrongly decided."

In sum, it was a good day for the medical community when the Ohio Supreme Court decided *Ruther v. Kaiser*. Ohio is now in line with the majority of jurisdictions; 32 states have these statutes in existence. ■

**Editor's note:** An amicus curiae expressing support for the appellate's position in this case was filed by several medical associations and the Ohio Alliance for Civil Justice (OACJ) — the AMCNO is a longstanding member of the OACJ and supported the appellate position in this case.

## AMCNO Convenes Alternative Dispute Resolution Work Group to Discuss Pilot Programs



Members of the ADR work group pose for the camera — left to right, Michael Shroge, Esq., Ed Taber, Esq., Marlene Franklin, Esq., Ohio Chief Justice Maureen O'Connor, Peter Weinberger, Esq., Paul Grieco, Esq., David Valent, Esq., Greg Popovich, Esq., and the Honorable Tim McMonagle.

Last year, the AMCNO convened a work group made up of plaintiff and defense attorneys, as well as AMCNO physician representatives and the Chief Justice of the Ohio Supreme Court. The work group received detailed background on a program operating in New York which was started as a judge-directed negotiation program. The program was directed to expediting the adjudication and early resolution of medical liability cases — in an effort to reduce administration/litigation costs. The work group also discussed the usage of special judges and special courts and the possibility of looking at a pilot program in Northern Ohio.

In April 2012, the AMCNO co-sponsored a seminar with the Cleveland Metropolitan Bar Association which focused on the topic of specialty courts and special dockets. As a follow up to that seminar, the AMCNO medical legal liaison committee discussed the topics covered and noted that based upon feedback from the attendees that it might not be feasible to set up a special medical court in Cuyahoga County, however, the committee agreed that perhaps the work group could consider another initiative, for example a case management order for malpractice cases.

The AMCNO recently reconvened the alternative dispute resolution work group to discuss the case management concept. The federal courts have something like this already where they differentiate case management — a standard track and a complex track. The set of rules that could be used would be similar to those used in the commercial court cases. One rule that might be helpful would be that the judge has to see the parties and the representatives within a certain period of time or number of days after the case is filed. In addition, the judges would have to rule on motions, with the intent to create a list of items that have to occur in a certain timeframe.

The work group plans to meet sometime in the future to consider coming up with a document addressing the possibility of setting up a pilot program which would include a unified case management order with the use of a special master for medical malpractice cases in Cuyahoga County. If this document is prepared and drafted by the work group, the work group would then have to take the document to the judges in Cuyahoga County in order to get input from the judiciary.

## Healthlines Format to Change in 2013

On January 1, 2013, WCLV FM/104.9 will change from a commercial to a noncommercial entity, aligning more closely with WVIZ Channel 25 and WCPN FM 90.3 — its public-broadcast colleagues at Ideastream. This move will essentially change the station to a nonprofit, and the station will support itself through grants, memberships and private donations.

As a result of this change, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) award-winning *Healthlines* program will move to an Academy of Medicine Foundation (AMEF) website – [www.amefonline.org](http://www.amefonline.org) – where the new *Healthlines* programs will be available for the public and the medical community on demand.

The *Healthlines* program will continue to be produced and edited by the WCLV studios and professional staff, along with the assistance of the *Healthlines* host, Dr. Anthony Bacevice, Jr. Promotional advertising spots will run on both WCLV FM 104.9 as well as WCPN FM 90.3 highlighting the *Healthlines* program with the intent to direct listeners to the new AMEF website. The AMEF promotional spots will contain information about the upcoming *Healthlines* interview and when the interview will be available on the AMEF website. The promotional spot will also include the name of the physician interviewee and the medical topic to be covered on the *Healthlines* program.

The AMEF website will include information about the foundation and a link to the new *Healthlines* program as well as a link to the AMCNO website – [www.amcno.org](http://www.amcno.org) - where an extensive archive of the *Healthlines* radio program is also available on demand.

The AMCNO and AMEF are pleased to continue our longstanding relationship with WCLV through this new concept, however, this is not the first time that the *Healthlines* programming or broadcasting venue has changed. The AMCNO sponsorship and hosting of a radio program dates back to 1958 when the AMCNO initiated a radio program called "The Doctor Speaks." This innovative program was the first of its kind in the country. The program had a decade-long run on WGAR from 1958 to 1967. Then in 1967 the AMCNO board of directors decided to

discontinue the current time slot format because popular radio tastes tended more toward shorter segments. Thus the current *Healthlines* radio program began.

The Academy of Medicine Education Foundation or AMEF as it is known, is the financial sponsor of *Healthlines*. While AMEF's mission is to enhance healthcare through education of the medical profession and the community, the purpose of AMEF is to add a charitable component to the AMCNO and partner with them in implementing new initiatives for both physicians and the patient population through charitable, educational and scientific efforts. AMEF and the physician members of the AMCNO reaffirm their commitment to the Northern Ohio community through their participation in the *Healthlines* radio program.

As a member of the AMCNO, you are welcome to participate in our award-winning *Healthlines* program, which will continue to be produced at the WCLV studios and be available on demand on the AMEF website. Guest appearances offer physician members a great opportunity where they can communicate important and up-to-date medical topics with the general public.

In the past, the *Healthlines* radio program was split up into three segments, approximately three minutes each, which then aired on WCLV on Monday, Wednesday and Friday. In the new format, programs will continue to be produced by WCLV and the interviews can be done either in person at the studio or by telephone and the interview will be done in one ten minute segment. The program uses a question-and-answer format with a topic selected by the physician. The *Healthlines* program will continue to be hosted by AMCNO past president and AMEF board member, Dr. Anthony Bacevice, Jr.

Scheduling a *Healthlines* program is just a phone call away. Our members may contact the Academy of Medicine of Cleveland & Northern Ohio at (216-520-1000) and ask for our communications department to let us know if you would like to be a guest on *Healthlines*. Staff will work with our members to arrange a recording time that meets your scheduling needs. Staff may also ask for a copy of your bio or if that is not available, your curriculum vitae to use as introductory information on the program. Physicians may be asked by staff to provide questions and answers on your topic for the host of the program. In addition, once the program has been recorded, you will be advised of when the program will be posted on the AMEF website so that you may inform your patients and your colleagues. You will also receive a certificate of appreciation for appearing on the program.

*Healthlines* is an excellent way for our members to provide information to the general public on timely, medically-related topics. It also provides you, our members, with the opportunity to get your name out in the community — truly a member benefit. For more information on the *Healthlines* program please contact the AMCNO at (216) 520-1000. ■

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CMS can help. Visit the CMS website at [www.cms.gov/ICD10](http://www.cms.gov/ICD10) for resources to get your practice ready.



## Another Successful Solving the Third Party Payor Puzzle Seminar Hosted by the AMCNO

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) hosted its 28th annual *Solving the Third Party Payor Puzzle* seminar on Wednesday, November 14, 2012. Insurance company presenters included Medical Mutual of Ohio, Anthem Blue Cross and Blue Shield, Medicare (CGS LLC), Ohio Department of Job and Family Services, United Healthcare, and Cigna Healthcare of Ohio.

Presenters from Medical Mutual of Ohio, Diana Irvin and Mellisa Kingery, kicked things off by discussing Medical Mutual's new website, [www.medmutual.com](http://www.medmutual.com), which they hope will decrease paper usage and unnecessary telephone calls by answering frequently asked questions and disseminating information online.

Anthem Blue Cross and Blue Shield presenter, Kristine Singer, addressed website navigation and updates, patient-centered primary care, and Availity®, Anthem's multi-payer portal solution. Questions were asked about claim problems with co-pays and Ms. Singer indicated that the best way to obtain help in this matter is on the secure messaging portion of the website. She also noted that Anthem has begun to distribute its *Network Update* newsletter through their eUPDATE.

Vanessa Williams, Provider Relations Senior Analyst of CGS LLC, provided updates on the new and updated Medicare initiatives, including the 2013 Medicare Physician Fee Schedule (available at [www.cgsmedicare.com](http://www.cgsmedicare.com)),

information regarding medical record review contractors, and updates on CGS operations. She also introduced new resources and self-service technology options, including prescribing procedures (eRx) and the Electronic Health Record (EHR) for patients. CGS is now on Facebook at [www.facebook.com/cgs.j15](http://www.facebook.com/cgs.j15).

Ms. Laura Gipson from the Ohio Department of Job and Family Services (ODJFS) discussed the MITS portal, eligibility, coordination of benefits, and laboratory claim issues. She noted that the MITS portal has been denying claims and they have been experiencing some technical difficulties where the organization's system has been taking longer to process electronic claims. She noted that ODJFS has been working diligently to resolve these problems.

UnitedHealthcare representatives, Dr. Linda Post, FAAFP, Medical Director; Terrilynn Blodgett, Sr. Physician Advocate; Amy Harts and Lisa A. Dragon; talked about protocols and administrative processes related to the



Linda Post, MD, FAAFP, Medical Director from UnitedHealthcare speaks to the group on new processes for 2013.

UnitedHealthcare Navigate® suite of health insurance products that emphasizes the role of the primary care physician in patient care and helps enhance the patient-doctor relationship.

Elizabeth Stipe, Sonja Magnani, and Patty Caley of Cigna Healthcare concluded the seminar by discussing the new utilities for workflow on their website. They demonstrated the new dashboard to easily access tools, the flagging systems to save to a dashboard, and new integrated functions such as the cost of care estimator and eligibility and claims.

The AMCNO would like to express our sincere thanks to all the presenters and we plan to offer the seminar again in 2013. ■

## Resident Seminar: The Business Aspects of Practicing Medicine

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) presented our annual seminar, *Preparing for the Business Aspects of Practicing Medicine* in October where Dr. James Sechler, AMCNO President welcomed residents and spouses from several area hospitals to learn about employment contracts, liability coverage, asset management, estate planning, starting a practice, and tax concerns from a lineup of expert guest speakers. The agenda's content and speakers targeted specific issues that young physicians will face entering today's healthcare marketplace. The seminar was presented by the AMCNO and sponsored by The William E. Lower Fund and The Academy of Medicine Education Foundation (AMEF).



Presenters: L – R From Walthall Drake & Wallace LLP: Cindy Kula CPA, Dick Cause CPA, Alicia Rice, Dave Grano, MBA, CRPC (Sagemark Consulting), Jim Spallino Jr (Squire Sanders), Rick Cooper (McDonald Hopkins LLC), Dr. James Sechler (AMCNO President), Phil Moshier CFP, CRPC (Sagemark Consulting).

The AMCNO and AMEF would like to thank the presenters Richard Cause, Cindy Kula and Alicia

Reiss from Walthall, Drake & Wallace LLP, Phil Moshier and David Grano from Sagemark Consulting, James Spallino Jr., from Squire, Sanders & Dempsey; and Rick Cooper from McDonald Hopkins, who were on hand to share their expertise.

The speakers provided insight on tax and non-tax issues of sole proprietorship and partnerships and introduced attendees to estate planning basics as well as what everyone should have on file such as a general Power of Attorney and a Living Will. Attendees also learned that a young family with children should have a Trust, a Living Will and a Durable Power of Attorney for health care. Tax basics, portability and the definition of a Revocable Trust were also topics of great interest.

Attendees also heard about key points of employment contracts where they were reminded that they must do their due diligence; and always conduct a non-economic appraisal of a practice. Attendees were advised to ask questions when reviewing an employment contract such as are the physicians geographically diversified or is the practice keeping pace with service delivery equipment and modalities? It is also important to remember that when you're negotiating the contract, that you are negotiating with the person of authority. It is important to take the time to consider and discuss the contract terms, and don't be afraid to ask the employer for reasonable changes — and always consider using legal counsel. Also, pay close attention to the malpractice coverage as well as the noncompetition and confidentiality clauses.

Presenters also covered the financial challenges that medical professionals face, including medical malpractice, asset preservation, liability exposure, tax brackets and estate taxation, noting that these are the reasons that financial planning is so important. The AMCNO offers this FREE seminar for residents every year. For more information please visit [www.amcno.org](http://www.amcno.org). ■

# AMCNO ACTIVITIES

## 2012 Vote and Vaccinate

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) hosted its thirteenth annual "Vote and Vaccinate" program on Election Day, November 6, 2012.

The intent of this annual program is to provide individuals with an opportunity to receive seasonal flu and pneumonia immunizations at various polling sites throughout Cuyahoga County, making it easier for people to get vaccinated before the flu season kicks into high gear. The AMCNO's Vote and Vaccinate Program runs parallel to the voting process and is not connected in any way with the Board of Elections.

The AMCNO was pleased to have participation this year from our program sponsors: Parma Community General Hospital, and Saint Vincent Medical Center. The AMCNO would like to express its sincere gratitude to site staff who participated in this worthwhile program at Marion Sterling School; North Royalton United Methodist Church; Parma Heights Baptist Church; Parma South Presbyterian Church; and Ridgewood United Methodist Church.



Mary Kiczek, RN – Parma Community Health & Wellness administers flu vaccine on Election Day at Parma South Presbyterian Church.

The AMCNO plans to host this community event again in 2013. If your group or hospital is interested in participating with the AMCNO as a co-sponsor or would like to host a site, please contact the AMCNO office at (216) 520-1000.

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## 2013 Cuyahoga Community College Center for Health Industry Solutions

Take advantage of discounted classes for AMCNO Members and their staff.

Contact AMCNO at (216) 520-1000 for exclusive AMCNO member course numbers to register and obtain a discounted price.

Date	Time	Title	Member-Fee	Location
2/5/13	6 – 8 pm	Hospital/Facility Billing Reimbursement – Tues & Thurs	\$237	CCE
2/18/13	6 – 9 pm	Essentials of Electronic Health Records – Mon & Weds	\$309	UTC
2/19/13	6 – 9 pm	Patient Access Specialist Fundamentals – Tues & Thurs	\$475	CCE
3/5/13	6 – 9 pm	Fundamentals of Billing Reimbursement – Tues & Thurs	\$354	UTC
3/6/13	6 – 9 pm	AAPC Professional Medical Coding Curriculum – Mon & Weds	\$1663	CCW
3/11/13	6 – 9 pm	Medical Front Office Fundamentals – Mon & Weds	\$475	CCE
3/19/12	6 – 9 pm	Medical Terminology – Tues & Thurs	\$333	CCE
4/1/13	6 – 9 pm	Essentials of Electronic Health Records – Mon & Weds	\$309	CCE
4/23/13	6 – 8 pm	Hospital/Facility Billing Reimbursement – Tues & Thurs	\$237	UTC
4/29/13	6 – 9 pm	Patient Access Specialist Fundamentals – Mon & Weds	\$475	UTC
4/30/13	6 – 9 pm	Medical Front Office Fundamentals – Tues & Thurs	\$475	UTC
5/7/13	6 – 9 pm	Fundamentals of Billing Reimbursement – Tues & Thurs	\$354	CCE
6/13/13	6 – 9 pm	Medical Terminology – Mon & Weds	\$333	UTC
6/10/13	6 – 9 pm	Patient Access Specialist Fundamentals – Mon & Weds	\$475	CCE
6/25/13	6 – 9 pm	Essentials of Electronic Health Records – Tues & Thurs	\$309	UTC
	6 – 9 pm	Medical Front Office Fundamentals – Tues & Thurs	\$475	CCE

Course Locations:

**Corporate College East** 4400 Richmond Rd, Warrensville Hts, OH 44128

**Corporate College West** 25425 Center Ridge, Westlake, OH 44145

**Unified Technologies Center Rd** 2415 Woodland Ave, Cleveland, OH 44115

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