Physician Leaders Take Aim at New Challenges in Health Care

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CMS can help. Visit the CMS website at www.cms.gov/ICD10 for resources to get your practice ready.
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The mission of the Michigan State Medical Society is to promote a health care environment which supports physicians in caring for and enhancing the health of Michigan citizens through science, quality, and ethics in the practice of medicine.
If that’s goal #1, then start with the right tools. The Medicare Learning Network® (MLN) develops informational resources just for Medicare Fee-For-Service providers. Billing errors can prevent physicians from receiving timely and proper reimbursement for common medical and surgical procedures. For example, the CMS’ Comprehensive Error Rate Testing (CERT) Program cites that a number of errors relate to non-compliance with Medicare coverage, coding, and billing rules.

Evaluation and Management (E/M) Services: Complying with Documentation Requirements is an MLN educational tool. It describes common CERT Program errors and provides information on the documentation needed to support certain claims to Medicare.

QUESTION: When can medical care be provided to a minor (someone less than 18 years of age) without the consent of the minor’s parent or legally appointed guardian?

ANSWER: As a general rule, physicians are prohibited from providing treatment to a minor unless the physician first obtains consent from the minor's parent or legally appointed guardian. The following is a list of common exceptions to this prohibition.

1. Emancipation: Consent of a parent or legally appointed guardian is not required if the minor has become emancipated. The legal consequence of a minor's emancipation is that parental rights to the custody, control, services and earnings of the minor are terminated. The minor's emancipation occurs automatically at age 18, and prior to age 18 can occur by the entry of a court order, the minor's marriage, entry into active duty with the US military, entry into police custody or when the minor is a state prisoner or probationer residing in a special alternative incarceration unit. Treatment for an emancipated minor who is in police custody or is a probationer is limited to routine, non-surgical medical care or emergency treatment when the parent or legally appointed guardian cannot be promptly located.

2. Emergency Care: Consent is generally implied in all emergency situations – including those involving a minor. Michigan statutes provide immunity from civil liability to physicians for the failure to obtain consent when rendering emergency care: (i) at the scene of an emergency if there was no prior relationship between the physician and the minor patient; and (ii) at a competitive sports event sponsored by a public or private school providing instruction in grades kindergarten through 12 or a charitable or volunteer organization. The statutory immunity would not apply in either situation if the physician is found to have been grossly negligent or to have engaged in willful and wanton misconduct in delivering the emergency care.

3. Pregnancy/Pre-Natal Care: A physician may provide pregnancy and pre-natal care to a minor without the consent of the minor's parent or legally appointed guardian. However, before providing the pregnancy or prenatal care, the physician must inform the minor patient that the permissive father of the child or the minor's spouse, parent, or guardian may be notified of the health care given or needed if the physician decides for medical reasons that such a notification is needed. Also, during the minor patient's initial visit to the physician for pregnancy or prenatal care, the physician must request the minor's parent's permission to contact the minor's parents for additional medical information that may be necessary or helpful to the provision of the proper pregnancy or prenatal care.

Note: an abortion procedure is not included within pregnancy or prenatal care. Except in cases of a medical emergency or when a court order waives the requirement of consent, a physician cannot legally perform an abortion on a minor without first obtaining the written consent of the minor patient and one of the minor's parents or legally appointed guardian.

4. Venereal Disease/HIV: Physicians may provide treatment for venereal disease or HIV to minor patients without first obtaining the consent of a parent or legally appointed guardian. As in the case of pregnancy or prenatal care, the physician may, for medical reasons, inform the minor's spouse, parent, guardian or person in loco parentis about the treatment given or needed to be given to the minor.

5. Substance Abuse: A physician may treat a minor who is or professes to be a substance abuser without obtaining the consent of a parent or legally appointed guardian. In this case also, the physician may inform the minor's spouse, parent, guardian, or person in loco parentis as to the treatment given to or needed by the minor.

6. Mental Health: A minor who has reached the age of 14 may request and receive mental health services on an out-patient basis without the consent of a parent or legally appointed guardian. Pregnancy termination referral services and the use of psychotropic drugs are excluded from this exception. The physician may disclose the treatment provided to the minor's parent, guardian, or person in loco parentis if the physician determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to another individual and the minor is informed of the physician's intent to inform the minor's parent, guardian, or person in loco parentis.

By Daniel J. Schulte, JD

EDITOR'S NOTE: If you have legal questions you would like answered by MSMS legal counsel in this column, send them to: Jessy Sielski, Michigan Medicine, MSMS, 120 West Saginaw Street, East Lansing, MI 48823, or at jsielski@msms.org.
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Radical changes are immediately ahead for our health care system. Changes featuring population-based health care, improved use of technology, performance- and outcome-based incentives and a surging wave of newly insured patients will push physicians closer to their scientific roots than the current fee-for-service system. They will also increase patient loads and the pressure for physicians to step up as leaders, within health systems and in large private-practice physician groups.

These changes have prompted a majority of physicians to move from the endless hours of dedicated clinical practice to “employed” arrangements, in which they are tasked with a wider range of responsibilities to cover during more limited hours. The physicians who do remain in private practice are moving from running their individual practice to more integrated structures that, similar to their employed counterparts, require new responsibilities.

Regardless of their employed or private-practice status, physicians will need to take the lead if our health system is to achieve the triple aim: patient-centered, cost-effective, high-quality care. We talked to several emerging and veteran physician leaders to mine their perspectives and discover how they are rising to the challenges ahead.

“I’d say that it’s imperative going forward that every health care system and every government agency should be looking toward clinical leadership, with physician leadership as the penultimate of clinical leadership,” said Betty S. Chu, MD. “I think it’s important that we have folks that are making decisions and planning strategy that have been involved in patient care.” Doctor Chu is Medical Staff President at Troy Beaumont Hospital and a member of the task force overseeing the merger between Beaumont Health System and Henry Ford Health System. She is a practicing obstetrician/gynecologist.

While there seems to be no argument that physicians, as a group, clearly possess the intellectual horsepower to become superb administrators, there is also widespread agreement that they have a lot to learn in an area where they generally lack training and experience. This becomes especially crucial as the health care system continues to become more sophisticated.

“I’m not going to say that [physicians] have the skills,” said Gregory J. Forzley, MD. “I think the fear and trepidation you get with physicians is everybody assumes that because you are a highly educated professional that you have all of those skills, you have all of the leadership capabilities, that you understand how to manage and run things, and that you can mentor people. That’s not part of our professional training. For some people, it seems to come naturally, but most of us have spent time trying to educate ourselves on those skill sets...”

Doctor Forzley is a longtime administrator who practiced for years before moving into administration. He is currently Chief Medical
Information Officer at Trinity Health and spends most of his time helping physicians in the Trinity System assimilate into an increasingly technological practice environment.

Doctor Chu is a rising physician leader who fully understands that clinical leadership and excellence aren’t enough in the changing health care climate.

“In the spring of 2011, when I was elected Medical Staff President, I decided to go to business school,” she said. “I’ll be graduating in a couple of months. For me, it’s been a very deliberate move from being a clinician to being an administrator. One, acquiring skills. Two, allocating the time. Three, becoming comfortable with the new concept of me as more of an administrator than a clinician, but still having a foot in the clinical world.”

Historically, physicians who make the jump from clinical practice to administration faced challenges within their own ranks and are challenged with staying in touch with their clinical side as they make the transition. Some of the physicians we interviewed maintain that physician/administrators must maintain at least a part-time clinical practice.

“I believe that you have to continue to practice, even if it’s a half-day or a day a week,” said Doctor Chu. “For me, I associate it with the plant manager who never steps onto the plant floor to talk to employees.”

“The challenge is finding the time and energy,” said Michael M. Mlsna, MD, who practices emergency medicine in Michigan’s Upper Peninsula and serves as medical director of that region’s only large physician group. “If I’m going to be an administrator, which is half of my career at this point, I can’t see myself not practicing and being a full-time administrator. I think there is too much you learn and go through on a day-to-day basis that you would quickly lose touch with if you weren’t practicing. I don’t look at it as much as a challenge, but more as an opportunity or requirement.”

And it’s not just about retaining respect from peers. Doctor Chu said she was able to detect the decrease in mammograms and other elective procedures at the outset of the 2008/2009 economic downturn well before it would show up on a hospital balance sheet. She saw an increasing number of her patients losing their insurance and putting off such procedures well before it would have registered in the books of a large system like Beaumont.

Robert J. Jackson, MD, MMM, is President of Accountable Healthcare Alliance and Accountable Healthcare Advantage, physician groups based in Allen Park. Over the years, he has steadily trimmed back his clinical practice to make more room for administrative responsibilities. While he spends about half of his time as a primary care physician and half in administration, for him, staying in touch is a matter of aligning
his interests with physicians as much as it is keeping a hand in active medical practice.

"Some physicians go from private practice to working for a hospital. They are not working on behalf of physicians. Even if your entire practice is solo, you are working on behalf of a physician, yourself, so you understand the needs and economics of the physicians you serve."

"There is forever the push and pull of, you're not seeing patients anymore so you're not a real doctor anymore," said Doctor Forzley, who has been in an exclusively administrative role for more than 20 years. "I didn't stop seeing patients because I was sick of it. It was because the role that I accepted required that I not have a clinical practice, and I languished over that for several months. But I still demonstrated that I can be credible with my peers. I can still understand the pain points that they have. I understand physician issues because I make it a point to stay up on those and not just focus on the activities that I'm involved with in my daily life."

Jack H. Carman, MD, began a primary care practice in 1976 and recently accepted a job as CEO of the Huron Valley Physician Association, a group practice in Southeast Michigan. "I just sent an email to a colleague that said the longer I work as just an administrator, the less effective I will be. I have to be careful, and they have to keep an eye on me too, [watching] for when I lose my effectiveness because I'm not in the trenches every day and I'm not feeling their pain," he said.

For those who choose to retain a clinical practice during their evolution into administrative roles, the challenges abound, but aren't without rewards.

"I was one of the rare primary care [physicians] who always had at least one to two-and-a-half days per week scheduled for something other than seeing patients," said Doctor Carman. "I kind of liked it, and this might be a selling point: I always wondered, 'how the hell do people just see patients five-and-a-half days a week?'

In addition to the challenges physicians face with their colleagues, in their ascending roles as administrators, they also face friction from the current ranks of non-physician administrators at a time when doctors' lack of formal training in administration is most exposed.

"How many CEOs of hospitals are physicians? I know of one big system in Wisconsin. There is a glass ceiling for physicians," said Doctor Jackson. "In a sense [there is the perception that], gee whiz, we can't understand business. Physicians are smart people, and a lot of physicians -- especially those in primary care -- study people and how to motivate them. So our people skills are not awful. And our analytical skills are generally well above average."

"I think that just by the nature of our training [we are qualified]," said Doctor Mlsna, Medical Director of Upper Peninsula Health Plan, the primary physician group for Michigan's Upper Peninsula. "Some of us have personality traits that are more favorable for administrative purposes. Anyone who has gone through our level of training and is providing patient care is inherently in a position for leadership."

"From the administrators' standpoint, I think they value the clinician input significantly," said Doctor Chu. "What I actually have found more is that the physicians themselves haven't embraced the role or developed the skills to speak the administrators' language or be able to solve problems the way an administrator would solve problems. The business world is a completely different mindset, and we need to cross that chasm and make sure that we're understanding their perspective just as well as they're understanding ours. Sometimes physicians don't do that very well."

"The typical physician who was in an administrative role in the past would come to a meeting with administrators and say, 'this is what I think needs to be done, please do it,' and wouldn't fully participate in that process in terms of trying to develop a plan or an idea," continued Doctor Chu. "The reality is that if they are going to respect you as a leader, you have to understand the difference between advocating and implementing; they are different skill sets and that's part of the reason I went to business school. What physicians need to learn is how to implement ideas. We haven't learned that skill. It's not that we're not smart enough to do it, it just takes time and deliberation and you have to be committed to it, just like any other skill set."

"My intent in looking for people to recruit into leadership positions and to get involved and kind of learn the future has been in that kind of 30 to 40 range because it seems like there's a group of them that have maintained an interest and desire to be involved leading their colleagues and supporting their colleagues," said Doctor Forzley.

"Within that group -- I can think of five off the top of my head that I have personally been involved with -- it is important to bring them forward and try to get them involved with leadership roles related to the future."

"You can offer them some monitored leadership experience; for example, running a committee, leading a project, those kinds of things," he said. "You can kind of coach them along when they run into problematic folks on both ends, meaning those who are willing to change and want to change everything versus those who don't want to change. So that's a nice guidance opportunity that you have if you can create that kind of relationship."

Perhaps the greatest challenge to a new generation of physician leaders is the changing culture of medicine and the internal struggles physicians face in meeting that change.

"I think you still have to let [potential physician leaders] be out there in the world for a while," said Doctor Carman. "Conveniently, that's also the time when they're most committed to their family. That's when children are young and they want to be home for their concerts and their soccer games and that sort of thing."

Robert J. Jackson, MD, MMM

Jack H. Carman, MD
"With my first 15 years of practice, I worked for myself, so my earnings were absolutely dependent upon how many people I saw, period. That was what controlled it. I knew that if I wanted to knock off at 4 o’clock because my kid had a cross country meet, I wasn’t going to earn as much, but that was more important to me than anything else.

“When I was asked to be Chief of Staff at the hospital where I worked, that was my first really big move that I knew was going affect my home life, and I always said I wouldn’t do it until my kids were in college,” he said. “And if that was my feeling a generation ago, you can imagine how people feel and think today. To their credit, they are not just married to their profession, they are married to their spouses and kids.”

That shift in focus has led to a lack of modern “giants,” physicians who were legendary in their breadth of clinical and administrative work and “married” to their careers, said Doctor Carman.

But with the resurgence of potential powerhouse physician leaders, perhaps a new breed of giants is coming; ushered in by mentors who might at first seem like strange bedfellows for physicians.

“There have been some physician role models for me,” said Doctor Chu, “but interestingly enough in my system, the CEO has been a role model. There are a couple of board members who have been role models – all of them non-physicians. Largely for me, my physician colleagues are tremendous role models in how they balance the work-life balance, but the skills that I was lacking came more from understanding the administrative mindset. I had great mentoring through MSMS on how to be a physician leader, but a physician executive is a different animal. We physicians haven’t had as many high-level executives yet – they will come, but they’re not here yet – so more influence comes from great administrators.”

As we have seen, the current challenges facing our health care system present a number of opportunities for physicians to become leaders in a number roles – health plan or health system executive, hospital chief of staff, chief medical officer of integrated groups, and a community leader, even as an elected official. However, the biggest challenge for physicians may be overcoming their reluctance to assume leadership positions previously unknown to them.

“I think sometimes as physicians, we are afraid to use the expertise we have. We assume that administrators know more than we do about health care,” says Doctor Jackson. “But we have a tremendous amount of knowledge and insight and the ability to transform health care so that the patients, our society, and the profession continue to be well served as we go forward. Physicians need to stop being reticent.”

As the next generation begins to ascend into leadership roles, both mentors and those they guide will have to embrace those opportunities and develop the skills to master to succeed at them.

“About 15 years ago, I started looking at trying to develop and bring other colleagues into the fold,” said Doctor Forzley. “I wasn’t really successful at that until about 10 years ago when we started getting more people involved in trying to give them guidance. So far, I’ve been successful in part of it, which has been getting them to be involved; I haven’t been as successful in all cases in getting them to focus on refining and adding to their leadership skills.”

Stacey Hettiger is Manager of Health Care Delivery at MSMS. Paul Natinsky is Managing Partner of Creatavision Partners, LLC, a Royal Oak, MI-based marketing, communications and digital media firm. Joe Neller is Director, Integrated Physician Advocacy at MSMS.
What has MSMS done for you lately to improve health care and the practice climate? In 2012, that kind of advocacy, as always, was a huge priority. We provided letters of support or opposition, hours of testimony to the House and Senate, and made hundreds of office visits, phone calls and e-mails. The work is ongoing, as you will read here. Highlights include:

Medical Liability Victory!
The largest victory for MSMS this year was the passage of reforms that return Michigan’s tort climate back toward what was originally passed by the legislature in 1993. It has been almost twenty years since there has been significant tort reform for medical malpractice in Michigan. These tort reforms will be good for physicians, but more importantly, good for patients.

Earlier in the year, MSMS worked on legislation to allow physicians who are employed to volunteer in clinics and be provided certain protections. It was a great day for medicine by opening the door to those physicians who wish to give of their time to help those who need it most.

Scope of Practice Clarified
Physician assistants and physicians came together to find ways to grow their partnership in medicine and came out of those discussions with Senate Bill 384, which brought more clarification of the relationship between PAs and physicians, strengthening it, providing greater avenues to provide the best care.

Physical Therapists made an attempt this year to provide direct access for patients, bypassing the physician. Nurses also were looking for some clarification on their profession and how they fit into the team approach. Both of these pieces of legislation did not make through the entire legislative process but MSMS is looking forward to continuing discussions with these groups to better strengthen the medical team in Michigan.
Autism Coverage
This legislative term saw the largest advancement in mental health parity in Michigan in decades. Michigan took a step towards that term by requiring the coverage of services surrounding the treatment of autism.

Impaired Drivers Reporting
An issue that MSMS has been working on for several years was accomplished this legislative term, providing liability protections for physicians who report to the Michigan Secretary of State that a person may be impaired to operate a motor vehicle. With the Governor’s signature on this legislation, physicians can report those patients they feel should not be operating a motor vehicle and let the Secretary of State decide whether that individual should be driving.

Graduate Medical Education Spared
The Governor has presented his last two budgets to the legislature with significant cuts to the program, citing that the priority should be funding Medicaid at a higher level. We understand the investment in Graduate Medical Education and the care this provides to those who need it the most. Through grassroots work and education of legislators we have been able to stay away from the deep cuts proposed by the Governor. In the coming years we will have to continue this fight to keep GME at its current level.
Engineer. Astronaut. Physician. Professor. James Bagian, MD, PE, would need several more heads to demonstrate just how many hats he has worn – and still wears every day. The Ann Arbor-based physician draws upon many aspects of that diverse background as he works to find better ways of ensuring efficiency and improving patient safety. Not to mention transcending the “F word.”

We shouldn’t be focusing on what happened or whose fault it is,” he explains, when speaking about medical adverse events. “Fault is the ‘F word’ in medicine. It’s not about the error or screwing up. We need to understand what caused the adverse event in the first place.”

Between appointments, the busy Philadelphia native takes time to talk about what drives him professionally and what he has learned about leadership along the way. Even on the phone, he emits a passion and enthusiasm for his profession(s) that is as infectious as it is admirable. It is also indicative of his warp-speed pace, in general.

Back in his Cub Scout days, Doctor Bagian first toyed with the notion of being an astronaut, but never thought of that as a realistic career goal. Instead, he pursued mechanical engineering, which he studied at Drexel University in Philadelphia.

While working professionally as an engineer (3M Corporation, US Department of Housing & Urban Development, US Naval Air Test Center), he pursued his medical degree at Thomas Jefferson University, also in Philly. After seeing an ad in a magazine for the NASA astronaut candidate program while still a medical student on an orthopedic surgery rotation, he jotted the information on the leg of his scrubs and decided to pursue his childhood dream. In 1980, that “unrealistic” dream became a reality.

**Culture of Safety**

When asked what his biggest misconception was about being an astronaut before his training, Doctor Bagian replies, “You really have no idea what it’s like until you do it. The percentage of time you actually spend on the shuttle is minute, as opposed to the time spent preparing for the mission.”

Doctor Bagian has a unique understanding of what works and what doesn’t when it comes to safety issues. He flew on

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**What is Leadership?**

“Any manager who tells people to do something isn’t going to get what they want. If people believe in what you want them to do, as a goal, they will walk through walls for you. But not just because you told them to do it. That’s leadership.”

—Doctor Bagian

Following the 1986 Space Shuttle Challenger disaster, it was discovered that the crew module hadn’t been “blown to pieces” and instead broke off. Doctor Bagian was then charged with leading a team to design, develop, and test a new shuttle escape system that would enable a crew to survive a situation like that in the future.

“Working on the escape system at NASA was challenging in many ways, especially technically,” he said. “People said it was impossible to do, but we did it. I’m much prouder of that than the missions I’ve flown.”

So how did his team accomplish the impossible? “If you invite [your team] to play, show them why there is a problem and ask how we work to make it better, then there is a buy-in. Then they own it,” he explained, also noting the importance of having a clear and compelling goal.

Going Beyond ‘Be More Careful’

Following his career at NASA, Doctor Bagian simultaneously served as the Chief Patient Safety Officer of the Veterans Health Administration, and Director of the VA National Center for Patient Safety from 1999 to 2010.

During this time, he says he learned even more about leadership. “You don’t get things done simply by sending emails. You articulate goals, establish a model, and create an environment that is conducive to getting things done.”

He also incorporates his engineering background/mindset to solving problems in medicine. He explains that engineers think about how to structure problems so they can be solved and proven and how things fit together as a system. “Engineering is quantitatively based,” he said. “Health care is more challenging because we don’t have as comprehensive of an evidence-based approach. There could be three different ways of doing something. But that is a disparity in practice that we shouldn’t be seeing. It’s not efficient and it’s not safe.”

He is quick to mention that it’s not just about safety. “Obviously, no one would want people to be harmed. But the point is finding out how we deliver care more effectively,” he emphasized. “Some physicians think this mindset takes away their flexibility or autonomy, but you want to do best job possible at understanding why and how patients can be harmed. It’s systems thinking. This is how we learn to mitigate problems.”

Above all, Doctor Bagian says, “We can’t rely on the typical response, which is: ‘Be more careful.’”

Sharing His Passion

Much of what Doctor Bagian does today is work with clinicians in hospitals, particularly the OR, and medical team training. He continues to teach at the University of Michigan Medical School, the U-M College of Engineering, the University of Texas Medical Branch, and Uniformed Services University of the Health Sciences in Maryland.

In 2010, he was appointed to the Board of Governors of The Doctors Company, the exclusively-endorsed professional liability carrier of MSMS. “Doctor Bagian is expert in devel-

Biggest Lesson He Learned in Space?

“In space? Nothing. Preparing to be in space? A lot. It taught me a lot about not jumping to conclusions, to have the facts right, to understand causation clearly, to not be pressured by political issues, and that sometimes what you find isn’t what you want to see.”

–Doctor Bagian
Doctor Bagian speaks at U-M in 2012 for a TEDx event called “Transforming Universal Communication.”

Watch the video at www.youtube.com/watch?v=t81kPlrNNzk.

oping system solutions for the prevention of adverse medical events,” said Richard E. Anderson, MD, FACP, chairman and CEO of The Doctors Company, in a statement. “His unique knowledge of medicine and engineering and his intimate familiarity with aviation’s culture of safety will substantially enhance our patient safety leadership.”

Somewhere along the way, Doctor Bagian even found time to develop an interest in and talent for woodworking. He has designed and built much of the furniture in his home.

“The hardest thing to say is ‘no.’ If there’s something worth doing, I want to do it. I talk to my kids about it a lot,” he explained. “My kids see I have passion for what I do and that work is not drudgery. I believe that if you have passion for what you do, you never work a day in your life.”

Speaking of family, NASA seems to be in the Bagian family’s blood. He met his wife, Tandi, also an engineer who now works for the Department of Veterans Affairs, while they both worked there. And some of their four kids have either interned or worked there at one time.

“I believe work should be fun and satisfying; that is the key. I stress for my kids to develop as many tools as possible so they have options and recognize opportunities. If you have the right skill set, you can do anything and find career passion anywhere.”

The author is Senior Manager, MSMS Communications & Public Relations.

BTW, Did We Mention He’s from Philly?

Tapping into another area of his expertise — his hometown — we couldn’t let Doctor Bagian go without getting a recommendation for a Philly cheese steak:

“Try Jim’s on South Street. The key is in the rolls. You just can’t find good Italian rolls outside of Philly!”

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After falling off the “fiscal cliff” for one day, Congress passed legislation to delay the full impact of $600 billion in scheduled spending cuts and tax hikes. The good news is that certainty was achieved in income and estate tax rates. The bad news is that most people will be paying more taxes in 2013. Washington lawmakers still have their work cut out as they need to address the debt ceiling issue by March while continuing to tackle the larger problem of the ballooning $16 trillion federal debt.

**Highlights of the Recent Tax Deal Include:**

- **Medicare** – One-year extension of the current Medicare reimbursement formula for doctors.
- **Income Tax Rates** – Permanently extends tax rates as well as other tax cuts enacted in 2001 and 2003. The exception is that single filers with taxable income over $400,000 and joint filers with taxable income over $450,000 will have their top tax rate increase from 35 percent to 39.6 percent.
- **Limits on Exemptions and Deductions for High-Wage Earners** – Reinstates the phase-out of personal exemptions and places limits on itemized deductions for single filers with adjusted gross income (AGI) above $250,000 and joint filers with AGI above $300,000.
- **Payroll Tax** – Increases the employee Social Security payroll tax to 6.2 percent on income up to $113,700 in 2013.
- **Capital Gains and Dividends** – Extends the 0 percent and 15 percent tax rates for long-term capital gains and qualified dividends for single filers with taxable incomes below $400,000 and joint filers below $450,000. The top rate increases to 20 percent for filers above these thresholds. The 3.8 percent Medicare tax was not repealed and will impact capital gains and dividends on modified adjusted gross income (MAGI) above $200,000 for individuals and $250,000 for couples filing jointly. As a result, four different rates are in effect depending on MAGI and taxable income: 0 percent, 15 percent, 18.8 percent and 23.8 percent. Sound confusing? You and your CPA are about to have an interesting conversation.
- **Charitable Rollovers** – Extends through 2013 the option for individuals to make tax-free rollovers from an IRA to a qualified charity.
- **Alternative Minimum Tax (AMT)** – Permanently extends the AMT patch with annual inflation adjustments.
- **Estate and Gift Tax** – Extends the lifetime and gift tax exemption of $5.12 million (with annual inflation adjustments), but increases the top tax rate from 5 percent to 40 percent.
- **Roth Conversions** – There are no income restrictions for a Roth IRA conversion. Plus, the tax bill now allows participants in 401(k), 403(b) and 457 plans to make Roth conversions, and pay the applicable tax bill, if their plan includes a Roth account option.

Avoid emotional decision-making as research has proven the merits of sticking to a disciplined investing strategy. Review your asset allocation to ensure your portfolio is aligned with your needs and risk level.

**Fiscal Cliff Avoided, For Now**

What You Should Do to Protect Your Hard-Earned Assets

By Nathan Mersereau, CFP, AAMS
So What are Smart Strategies to focus on in light of these changes?

• Focus on What You Keep, Not What You Earn. With rising tax rates, it’s more important than ever to have a tax-efficient investment and retirement income plan. Consider minimizing taxable gains using tax-loss harvesting strategies and placing high dividend, high turnover investments in a tax-deferred account such as a 401(k) or IRA. Maximize pre-tax savings which will in turn lower your taxable income.

• Focus on Keeping Uncle Sam Away from Your Estate. Consider consulting with an estate planning attorney to examine charitable giving, trust or ownership strategies that will facilitate an efficient transfer of wealth to your loved ones or favorite causes.

• Focus on the Long-Term. The financial media will do its best to captivate you with details on the crisis of the month. Markets may once again become volatile as Congress gets ready to revisit the debt ceiling issue. Avoid emotional decision-making, as research has proven the merits of sticking to a disciplined investing strategy. Review your asset allocation to ensure your portfolio is aligned with your needs and risk level.

Many physicians are caught up in a busy schedule and feel they have limited time to invest in themselves. But taking time to review your financial plan and even seeking a second opinion is time well spent. Call a WealthCare Advisor at 888-958-1990 to make sure you have a sound financial strategy during these times of change. Or visit www.wealthcareadvisors.com.

The author is President of WealthCare Advisors, LLC.

Drug-Related Adverse Events on the Rise: Protect Yourself from Claims

Contributed by The Doctors Company

Medication-related errors involving narcotic analgesics are not only a patient safety concern, but also a cause of significant professional liability for physicians and other prescribers.

Over the past decade, the number of adverse events related to inappropriate prescribing, misuse, and abuse of prescription painkillers has substantially increased in the US. In 2010, two million people – nearly 5,500 a day – reported first-time, nonmedical use of prescription painkillers during the previous 12 months.\(^1\) Such drugs cause more deaths than heroin and cocaine combined,\(^2\) and drug-related deaths exceed deaths from traffic fatalities.\(^3\)

Narcotic analgesics are the most common class of medications that can lead to a medication-related error claim, according to a study by The Doctors Company, the nation’s largest medical malpractice insurer. Some 5.8 percent of 2,646 closed claims analyzed by The Doctors Company in 2011 contained medication-related errors. Of these, narcotic analgesics were the most common class of medications identified (17.5 percent of claims).

The US Food and Drug Administration (FDA) has mandated a Risk Evaluation and Mitigation Strategies (REMS) program for prescribing extended-release and long-acting opioid analgesics. The FDA will implement this voluntary program on March 1, 2013. As part of the program, the FDA is requiring opioid manufacturers to provide grants to fund continuing medical education (CME) programs to advance prescriber understanding and safe use of pain medications.

In addition to completing CME programs, doctors can reduce risk by incorporating electronic prescribing, also known as e-prescriptions, into their practice. Electronic prescribing removes the time-intensive process involved with tracking paper prescriptions, voids opportunity for alterations, and allows direct connection to pharmacists to ensure accurate prescriptions.

Other tips for avoiding narcotic analgesics claims include:

• Require office visits for obtaining controlled medication prescriptions.

• Note actual amounts prescribed, and give matching numerals to discourage prescription alterations (e.g., thirty/#30).

• Attend seminars to educate yourself on safe prescribing practices.

The Doctors Company is the exclusively endorsed medical liability carrier of the Michigan State Medical Society (MSMS). We share a joint mission of supporting doctors and advancing the practice of good medicine. For information about the company, visit www.thedoctors.com.

References


What Physicians Need to Know About Accountable Care Organizations under the Medicare Shared Savings Program

By Patrick J. Haddad, JD
Kerr, Russell and Weber, PLC, MSMS Legal Counsel

August 2012

Physicians need to become familiar with various issues relative to Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program, so they can make informed decisions about whether to participate or to wait and see whether these organizations take root.

MEDICARE SHARED SAVINGS PROGRAM
The Medicare Shared Saving Program (MSSP) was authorized by the Patient Protection and Accountability Act of 2009. Under the MSSP, ACOs will assume responsibility for the clinical and financial outcomes of care furnished by physicians and other ACO participants to a group of Medicare beneficiaries. ACOs themselves will not function as suppliers or providers of medical care enrolled in Medicare. Medicare will continue to pay physicians and other Part B suppliers on a fee-for-service basis and will continue to pay hospitals and other Part A providers under existing prospective payment methodologies. Medicare will require ACOs to apply for participation in the MSSP, and ACOs accepted into the MSSP will be required to enter into participation agreements with Medicare for a three-year period.

Issues that physicians need to understand about Medicare’s ACO standards include the following:

• Method for assignment of beneficiaries. An ACO must have a minimum of 5,000 Medicare beneficiaries attributed to it and have sufficient primary care physician participation to serve this population. CMS will treat an ACO as satisfying the beneficiary attribution threshold if 5,000 or more Medicare patients were assigned to ACO physicians in each of the three years before the ACO’s commencement date. ACOs that fall below 5,000 beneficiaries will be terminated from the MSSP program. Medicare beneficiaries, however, retain freedom of choice and will not be obligated to seek services from physicians or others participating in an ACO.
Best Practices for Creating an Accountable Care Organization

Contributed by The Doctors Company

The US health care system is moving toward Accountable Care Organizations (ACOs), groups of health care providers who agree to be accountable for the quality, cost, and overall care of Medicare patients. According to the Future of Health Care Survey conducted by The Doctors Company, the nation’s largest medical malpractice insurer, 57 percent of physicians are either undecided or need more information regarding ACO participation. In a video series at www.youtube.com/doctorscompany, health care industry thought leaders recommend the following best practices when forming ACOs:

1. Create a Readiness Checklist.
   “A readiness checklist... involves things like patient-centered medical homes and the attributes that primary care physicians have,” said Robert J. Jackson, MD, MMM, president and medical director, Accountable Healthcare Alliance in Michigan. “It talks about, ‘How well do we deal with data? Do we have patient registries? Do we have patient care plans? Do we have transition of care issues developed?’”

   “The key is designing the care management tools, resources, people, and interventions to..."
manage the specific needs of that patient,” said Laura P. Jacobs, MPH, executive vice president, The Camden Group in California.

3. Develop Clinical Integration.
“Make sure all the providers are engaged in real-time information sharing so a care plan can be developed within a very quick period of time and all the providers know their roles and the timelines in which they have to perform their services,” said Michael H. James, JD, president and CEO of Genesys PHO, a pioneer ACO, and Genesys Integrated Group Practice in Michigan.

4. Engage the Community.
“The community has to support programs that improve health and improve the way patients live because health care goes beyond just acute care,” James said. “It involves the patients’ safety, whether they have enough to eat, their transportation, education, business opportunities or employment opportunities.”

5. Select the Right Board Members.
“A pioneer ACO requirement is to expand the board with a patient and a community advocate,” James said. “Genesys selected the leader of their volunteer group. He is 72 years old and is very engaged and involved in community studies on how to improve access to care. The community advocate is the executive director of a group of nursing homes.”

For more risk tips, patient safety tips, and physician practice tips, visit www.thedoctors.com.

BUSINESS PLAN AND FINANCIAL MODEL
A top priority for physicians is to review and understand the ACO’s business plan and financial model. For example, what capital is required for the ACO to commence its operations, how will that capital be raised, and are physicians required to invest cash or make other contributions? Will capital be contributed to the organization in the form of equity or debt and if so, under what terms?

Importantly, physicians need to understand the key assumptions underlying the business plan and financial model and to identify the risks and other factors that could cause those assumptions not to materialize and which could have an adverse impact on the ACO and its participating physicians and other providers. Among other things, physicians should focus on the financial model’s projected savings—or losses (whether start-up or otherwise)—and understand what is projected, over what period, and if the organization will distribute savings to the physicians or retain savings for reinvestment. In the event that a hospital participates in the ACO, the physicians need to understand how savings or losses will be allocated among the physicians and hospital, and under what circumstances.

An ACO should be prepared to educate potential physician participants on these and other business issues, including if the ACO has taxable or tax exempt status, if the ACO will be subject to accrual or cash based accounting treatment, and if savings or losses will be distributed to the physicians and other participants as contractual obligations or as equity distributions.

REGULATORY ISSUES
ACOs implicate various health care regulatory issues. For this reason, various agencies of the federal government have furnished guidance and have waived various compliance obligations relative to the antikickback statute, the Stark self-referral regulations and civil monetary penalties relative to gain sharing and beneficiary inducements. Additional guidance has been furnished relative to federal antitrust laws and by the IRS relative to tax exempt organizations. These waivers and guidance statements are limited to an ACO to the extent that it participates in the MSSP and, even then, certain waivers and guidance statements govern only limited aspects of such participation. These waivers and guidance statements do not extend to a physician’s private medical practice outside of ACO participation.

It will be important for physicians and other ACO participants to be assured that the ACO has been structured to be compliant with the MSSP standards, as well as other health care regulations. Physicians may have this assurance only to the extent that a properly structured ACO is operated in a compliant manner, so the ACO must have a management team, whether internal or external, which is fully aware of the need for compliance in the highly regulated Medicare environment.

CONCLUSION
ACOs, at least initially, may not have appeal for all physicians. Nevertheless, physicians should ensure that they understand the various legal and business aspects of ACOs, so that they can make informed decisions relative to participation, particularly if ACOs and the MSSP gain traction with and are mimicked by private payers.
Since the inception of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, specialists have been concerned about their ability to meet objectives, tied to specific measures, which must be achieved in order to successfully demonstrate the “meaningful use” of EHR technology.

Under Stage 1 criteria, physicians and other eligible professionals (EPs) must collect and report data on 20 out of 25 identified measures, as well as at least six clinical quality measures (CQMs). Because not every meaningful use measure applies to every EP, specialists often question how they are to proceed. The Centers for Medicare and Medicaid Services (CMS) has responded to these inquiries by creating a new tip sheet that explains how specialists should approach the core and menu measures, and the availability of exclusions for some of the measures that may have no relevance to the specialist’s scope of practice.

The CMS Meaningful Use for Specialists Tip Sheet (updated in January 2013) is printed below in its entirety.

Recognizing that not every meaningful use measure applies to every provider, this fact sheet gives specialty providers tips about how to successfully meet meaningful use measure requirements and navigate the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

Are you facing measures that require data you don’t normally collect as a specialist? While eligible professionals can choose measures that apply to their practice, in some cases, data that has been collected by another provider – for example, a referring physician – can be used to fulfill required measures.

Meeting Meaningful Use

In the EHR Incentive Programs, there are exclusions that exempt physicians/providers from meeting specific objectives for meaningful use. Those who meet the qualifications for an exclusion will not need to report on that objective and can still receive an EHR incentive payment.

Core Measures

All providers have to either meet or qualify for an exclusion to every core measure of the EHR Incentive Programs. Exclusions are not based on specialty, but rather on unique criteria for each exclusion. For instance, if recording vital signs (height, weight, and blood pressure) has no relevance to a specialist’s scope of practice, he or she does not need to record them for that measure.

Some exclusion criteria may be universally or nearly universally applicable to a specialty due to the scope of practice of that specialty. However, because there is no blanket exclusion for any type of EP, specialists must individually evaluate whether they meet the exclusion criteria for each applicable objective.

Menu Measures

Providers must select five menu objectives on which to report from the total list of available 10 objectives. However, it is possible that none of the menu objectives are applicable to a particular specialist’s scope of practice. If that is the case, you can usually qualify for the exclusions to the objectives. For example, an EP who writes fewer than 100 prescriptions during the reporting period can claim an exclusion to the objective for implementing drug formulary checks. Thus, specialists who do not prescribe medications could claim the exclusion for this objective.

If you qualify for all of the exclusions for each of the menu objectives, then select any five menu objectives during attestation and claim the exclusion for each. However, please note that if specialists do not qualify for all of the exclusions to the menu objectives, they should go back and select menu objectives on which they can report.

Clinical Quality Measures

All providers must report on clinical quality measures (CQMs) in order to demonstrate meaningful use. Specialists are not excluded from this requirement. A number of the available CQMs are applicable to specialists, and CMS suggests that specialists pick quality measures that are relevant to their practices and clinical workflow.

However, if none of the CQMs are applicable to your scope of practice, your EHR should generate zero values for all of the CQMs since there are no patients in the EHR to whom the quality measures are applicable. Zero is an acceptable value for the CQM denominator, numerator, and exclusion fields during attestation and will not prevent you from demonstrating meaningful use or receiving an incentive payment.

If you are a specialist whose EHR generates zero values for all of the CQMs, you should enter zeros in the denominator, numerator, and exclusion fields for the three Core CQMs during online attestation. The online attestation system will then prompt you to enter information for three Alternate Core CQMs, for which you will also enter zeros in the denominator, numerator, and exclusion fields. You may then select any three measures from the list of 39 Alternate CQMs and report zeros in the denominator, numerator, and exclusion fields. This will complete your CQM attestation.

Using Data Entered by Other Providers

CMS encourages specialists to use data supplied by referring and other providers – or accessible through a Health Information Exchange (HIE) – to comply with the meaningful use reporting requirements. CMS understands that some specialists do not interact with patients in the same way as general practitioners. Specialists may not have direct contact with their patients, may not have a need for follow up after an office visit, or may not transition patients to another setting of care themselves, so information exchange, either directly or through an HIE, can be an excellent solution for obtaining reporting data.

Please note that neither the HIE nor the referring provider must have certified EHR technology in order for you to incorporate this information into your EHR for the purposes of meeting the meaningful use objectives. Where the information comes from is unimportant as long as you use your certified EHR technology to record and store it.

Specialists who share an EHR with other providers also can count in the numerator those patients for whom other providers have entered information. While there are many objectives that require the recording of standardized patient information, these objectives do not specify who should enter the information. Therefore, a shared EHR,
documentation accompanying referrals and orders, or receiving information through electronic exchange are excellent strategies for meeting these objectives.

**Clinical Summaries: Determining Office Visits**

A specialist who does not have office visits with patients is excluded from the meaningful use objective to “provide clinical summaries for patients after each office visit.” For the EHR Incentive Programs, an office visit includes separate, billable encounters that result from evaluation and management services provided to the patient. While CMS does not specify a range of E&M billing codes to which this exclusion applies, we define office visits as:

1. Concurrent care or transfer of care visits
2. Consultant visits*, or
3. Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health).

*A consult visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

If you do not have any visits that fit into the three categories above, you may claim the exclusion for this objective.

If a patient is seen by multiple EPs who share an EHR, a single clinical summary at the end of the visit can be used to meet the objective. Therefore, a specialist who does not interact with the patient can also count the clinical summary provided by the other EP(s) who saw the patient in order to fulfill this requirement.

**Hardship Exceptions**

CMS recognizes that even with the available exclusions and the flexibility of obtaining information through electronic exchange, certain specialists may find it difficult to demonstrate meaningful use. These specialists may apply for a hardship exception to avoid the EHR Incentive Program payment adjustments that begin in 2015. Information on applying for a hardship exception will be available soon. (For more information about payment adjustments in general, please visit [http://go.cms.gov/1165ICJ](http://go.cms.gov/1165ICJ))

Specialists and other providers who apply for a hardship exception based on limited interaction with patients must demonstrate that they:

- Lack of face-to-face or telemedicine interaction with patients; and
- Lack follow-up need with patients

CMS also recognizes that certain providers who practice at multiple locations are unable to demonstrate meaningful use because of lack of access to Certified EHR Technology at one or more locations. If you are a specialist or other provider who lacks control over the availability of Certified EHR Technology at one or more of your practice locations and therefore cannot use Certified EHR Technology at practice locations for 50 percent or more of your patient encounters, you may also apply for a hardship exception to the payment adjustments.

**CMS Resources for Meaningful Use**

CMS has created a series of resources to help specialists successfully participate in the EHR Incentive Programs. Some of these resources include:

- **Stage 1 Meaningful Use Calculator** – Allows providers to test whether or not they would successfully demonstrate meaningful use for the EHR Incentive Programs.
- **An Introduction to the Medicare EHR Incentive Program for Eligible Professionals** – Walks EPs through all of the phases of the Medicare and Medicaid EHR Incentive Programs, focusing on Stage 1 meaningful use requirements.
- **Stage 2 Specification Sheets** – Includes the objective, measure, and exclusion for each Stage 2 core and menu objective, as well as a definition of terms, attestation requirements, additional information, related FAQs, and the corresponding standards and certification criteria.

**Roman I. Krivochenitser from Michigan State University College of Human Medicine Grand Rapids Receives Top Award at AMA Research Symposium**

Roman I. Krivochenitser, (center) a member of MSMS and a third year medical student at Michigan State University College of Human Medicine Grand Rapids, was the overall winner in the public health and epidemiology category for his research titled, “Adolescent Patients with Sexually Transmitted Infections: Who Gets Lost to Follow-up?” during a research symposium at the American Medical Association’s Interim Meeting.

“The work of Roman and the other young physicians and medical students shows us that the future of medicine looks very bright,” said AMA President Jeremy A. Lazarus, MD. “The research presented at this AMA symposium provides valuable information for current and future physicians. These advances will help them provide the best possible care for patients.”

Krivochenitser received the award in the medical student category. The symposium consisted of separate competitions for AMA member who are residents or fellows, medical students and international medical graduates that are certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and awaiting residency.

More than 600 abstracts were submitted for consideration this year, the most in the research symposium’s 10 year history. The award program began in 2003 to provide leadership opportunities for medical students, residents and fellows who are interested in research.
The 2012-13 influenza season began about a month early, and as of mid-January, influenza activity is “widespread,” the highest level on influenza activity, in a majority of the states. In Michigan, influenza activity increased to widespread the week of January 3, 2013, and as of this writing, widespread activity continues. Four influenza-associated pediatric deaths have been reported so far this season to the Michigan Department of Community Health (MDCH). The deaths occurred in a six-month-old, a six-year-old, a 13-year-old and a 14-year-old. Since influenza-associated pediatric deaths became reportable in 2004, the highest number of deaths reported in one season to MDCH was six during the 2010-11 flu season. These deaths are a somber reminder of the danger flu poses to children.

MDCH recommends that everyone six months of age and older get a seasonal flu vaccine each year. Some children six months through eight years of age require two doses of influenza vaccine. The second dose should be given at least 28 days after the first dose. The Michigan Care Improvement Registry (MCIR) can tell providers whether or not two doses are recommended for children. In addition, new MCIR rules were implemented this season and providers are required to report influenza vaccinations administered to every child less than 20 years old within 72 hours of administration into MCIR. For more information, visit www.mcir.org.

How well the flu vaccine works can vary from year to year and from one person to another. On January 11, 2013, the Centers for Disease Control and Prevention (CDC) published a Morbidity and Mortality Weekly Report (MMWR) on 2012-13 influenza vaccine effectiveness (VE). Findings from the interim study suggest that this season’s vaccine is reducing the risk of having to go to the doctor for influenza by about 60 percent for people who got vaccinated. This is considered a moderate rate of VE compared with the effectiveness of many childhood vaccines. Increasing influenza VE is needed; however, the current flu vaccine offers the best protection we have against influenza right now. Additionally, influenza vaccination, even with moderate effectiveness, has been shown to offer substantial other benefits including reducing illness, antibiotic use, time lost from work, hospitalizations, and deaths.

While difficult to predict, it’s likely that influenza activity will continue into the spring months. It is not too late to vaccinate. Anyone six months and older who has not gotten vaccinated yet this season should get vaccinated. Vaccine providers are encouraged to maintain adequate flu vaccine supplies and urged to continue to vaccinate. If vaccine inventory is an issue, please check with your local health department for the latest information on influenza vaccine supply.

Influenza vaccination to prevent influenza and prompt antiviral therapy to treat influenza illness are the two most important medical defenses against the influenza viruses. On December 21, 2012, the US Food and Drug Administration (FDA) approved the influenza antiviral medication oseltamivir (trade name Tamiflu®) for the treatment of influenza in people two weeks of age and older. Previously, oseltamivir was approved by FDA for treatment of influenza in persons one year of age and older. Antiviral treatment initiated as soon as possible is especially important for people who are very sick with influenza, such as those requiring hospitalization, and people who are at high risk of developing serious influenza-related complications, such as young children, people 65 and older, people with certain underlying chronic conditions, and pregnant women.

For More Information

For additional resources and to access MDCH’s weekly surveillance report, Michigan Flu Focus, and weekly influenza newsletter, FluBytes, visit www.michigan.gov/flu.
The members of the Michigan State Medical Society remember with respect their colleagues who have died.

C. Peter Behme, MD
Saginaw, died October 21, 2012, at the age of 84.

Lawrence C. Hazen, DO
Saginaw, died December 3, 2012, at the age of 69.

Henry R. Hug, MD
Austin, TX, formerly of Saginaw, died April 14, 2012, at the age of 77.

Rudolph M. Jarvi, MD
Saginaw, died August 18, 2012, at the age of 89.

Harry E. Lichtwardt, MD
Novi, died November 22, 2012, at the age of 93.

Joseph D. Mann, MD
Grand Rapids, died December 27, 2012, at the age of 87.

Donald R. McCorvie, MD
Williamston, died November 17, 2012, at the age of 85.

Roger F. McNeill, MD
Grosse Pointe, died October 18, 2012, at the age of 88.

Morris J. Mintz, MD
Southfield, died November 5, 2012, at the age of 101.

Mohammed A. Razzaque, MD
Northville, died September 29, 2012, at the age of 67.

Herschel A. Shulman, MD
Southfield, died November 23, 2012, at the age of 94.

Hugh L. Sulfridge, Jr., MD
Saginaw, died November 22, 2012, at the age of 97.

Correction from Nov/Dec 2012 Issue:
Narinder K. Sherma, MD
Farmington Hills, died November 16, 2012, at the age of 68, not 84.

IN MEMORY
If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, the physicians’ own charity, please contact Rebecca Blake, Director, MSMS Foundation, 120 W. Saginaw, East Lansing, MI 48823, call 517-336-5729 or send e-mail to rblake@msms.org.

Welcome to These New MSMS Members

Esa M. Ali, MD, Waterford
Laxmi Vasudha Devisetty, MD, Saginaw
Suzanne Lorae Dooley-Hash, MD, Ann Arbor
Stephanie Wise Grosvenor, DO, Marquette
Krista Marie Haines, MD, Grand Rapids
Amanda R. Henry Minor, DO, Battle Creek
Arwa Mohamed Hosni, MD, Ann Arbor
Jorrie Anne Houle, DO, Marquette
Timothy Hugo Kaufman, MD, Saginaw
Flora Kim, MD, Ann Arbor
Robert Andrew Knapp, MD, Ann Arbor
Joseph Gordon Krainin, MD, Grand Rapids
Kara L. Krol, MD, Grand Rapids
Bryan Ting-Yen Lin, MD, Ann Arbor
Sean Patrick Logan, MD, Ann Arbor
Caitlin Carr Lopez, MD, Ann Arbor
Karen Nichole McFarlane, MD, Fort Gratiot
Troy E. Pasco, MD, Battle Creek
Frank William Pavlovic, DO, Ann Arbor
Kimberly A. Rice, MD, Grosse Pointe Park
Jacob Edward Roberts, DO, Commerce Township
Jonathan D. Rose, MD, Bloomfield Hills
Sharon D. Rouse, DO, Jackson
Rachel Marie Munoz Sawaya, MD, Ann Arbor
Nicholas J. Schoch, DO, Saint Clair Shores
Matthew J. Schramski, DO, Saint Clair Shores
Angela Marie Schultz, MD, Saginaw
Devon Newman Shuchman, MD, Ann Arbor
James Jonathan Slater, DO, Petoskey
Gregg John Stefanek, DO, Alma
Sean Rayl Stephenson, DO, Troy
Allan John Wilke, MD, Kalamazoo
Brittany Johanna Williamson, DO, Manitou Beach
Happy New Year!

By Kathy Adams

I started writing this article during the busiest, most celebrated time of the year. Trying to come up with a topic when my head was full of things like how big of a turkey I need to feed 20 people, why this string of lights won’t work, and where I put the wrapping paper I bought last year seemed like a daunting task. Then I paused and told myself to remember what this season is about, and to try to carry forward the good feelings it fosters. With that in mind, I started a list of some of the reasons I am happy and grateful for the many things I enjoy during all the seasons of the year:

- A husband who supports me in the endeavors I pursue
- Playing monopoly with my seven-year-old, property-amassing, tycoon grandson
- Watching my 10-year-old granddaughter competitively swim with speed and grace
- Delivering “Meals on Wheels” with my 15-year-old grandson and having a discussion about why meals on wheels are needed
- Children who are grown and on their own but live nearby
- Eating peanut M&Ms
- Watching Big Ten football
- Walking and running (at my age!) and enjoying it
- Traveling to places far (like Australia) and near (like Greenfield Village)
- Family reunions
- Volunteering at a food pantry and being able to give out food instead of receiving it
- Making Christmas happen for a family besides my own
- Friends
- Going out for breakfast
- Swinging in a porch swing and watching kids chase lightning bugs on a summer evening
- Listening to rain outside an open window while in bed at night
- Watching logs burn in the fireplace
- Hearing “Stars and Stripes Forever” and watching fireworks with a lump in my throat on the 4th of July
- Having those 20 people (some of whom are Jewish, Hindu, as well as Christian) for Christmas dinner, and relishing the chaos and joy in family and friends and being together

What does this short and incomplete list mean? Probably not much; it’s just a reminder that we savor the moment, whatever the moment may be, and create a happy 2013 from the moments of our lives.

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
The Patient Centered Medical Home: Coordinated Care, Optimal Outcomes
Date: Wednesday, March 13, 2013
Time: 9:00 a.m. to 3:45 p.m.
Location: Somerset Inn, Troy
Intended for: Physicians, practice managers/administrators, executives, and all other health care professionals.

Weight of the State: A Conference on the Causes, Prevention and Management of Obesity
Date: Wednesday, May 8, 2013
Time: 8:45 a.m. to 4:15 p.m.
Location: The Inn at St. Johns, Plymouth
Contact: Caryl Markzon (517) 336-7575 or cmarkzon@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians, practice managers/administrators, executives, and all other health care professionals.

Conference on Women's Health
Date: Thursday, May 16, 2013
Time: 1:00 p.m. to 4:15 p.m.
Location: Somerset Inn, Troy
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org
Intended for: Physicians, residents, and medical students.

Doctor Joseph S. Moore Conference on Maternal and Perinatal Health
Date: Thursday, May 16, 2013
Time: 9:00 a.m. to 4:15 p.m.
Location: Somerset Inn, Troy
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org
Intended for: Physicians, residents, physician assistants, nurses, and others who are engaged in health care with special emphasis on improving care for mothers and their infants.

Spring Scientific Meeting
Date: Thursday, May 16, & Friday, May 17, 2013
Time: Concurrent courses run daily from 9:00 a.m. to 12:15 p.m., 1:00-4:15 p.m., and 5:00-8:15 p.m.
Topics: Infectious Disease, Cardiovascular, Neurology, Endocrinology, Rheumatology, Dermatology, Pain Management, Asthma/Allergy and Epilepsy.
Location: Somerset Inn, Troy
Contact: Marianne Ben-Hamza, (517) 336-7581 or mbenhamza@msms.org
Note: Continental breakfast and lunch will be provided. Dinner will be provided in evening course.
Intended for: Physicians and all other health care professionals.

Audits and Payer Incentives: Show Me the Money
Date: Wednesday, June 5, 2013
Time: 9:00 a.m. to 4:00 p.m.
Location: The Inn at St. John’s, Plymouth

Contact: Marcie Barnum, (517) 336-5724 or mbarnum@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians, administrators, office managers, and all other health care professionals.

Health Information Technology (HIT) Symposium
Date: Wednesday, June 12, 2013
Time: 9:00 a.m. to 3:30 p.m.
Location: MSMS Headquarters, East Lansing
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians, administrators, office managers, and all other health care professionals.

Michigan Conference on CME Accreditation
Date: Thursday, August 8, 2013
Time: 8:00 a.m. to 4:00 p.m.
Location: Bavarian Inn, Frankenmuth
Note: Continental breakfast and lunch will be provided.
Contact: Brenda Marenich, (517) 336-7580 or bmarenich@msms.org
Intended for: Physicians, CME leaders, educators, coordinators, and CME administrative staff members.

Transitioning to Accountable Care Organizations
Date: Wednesday, September 18, 2013
Time: 9:00 a.m. to 3:30 p.m.
Location: The Inn at St. Johns, Plymouth
Contact: Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians administrators, office managers, and all other health care professionals.

To Register Online:
www.msms.org/eo

Mail:
MSMS Foundation
PO Box 950
East Lansing, MI 48826-0950

Fax:
517-336-5797

Phone:
517-336-5785
The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Community Health Bureau of Health Professions.

**Report Dated:**

10-8-2012 through 10-12-2012

Tete Eshyonzo Oniango, MD
Dearborn, MI
Drug Control License
53-15-039041
43-01-091134
10/10/2012
Fine Imposed
Probation
Technical Violation of the Michigan PHC

**Report Dated:**


Hojjat Montazer M. Shamloo, MD
Bedford, IN
Report Dated:
Technical Violation of the Michigan PHC
Probation
Fine Imposed
43-01-093586

**Report Dated:**

10-22-2012 through 10-26-2012

Brad A. Botvinick, MD
Birmingham, MI
43-01-089224
10/24/2012
Summary Suspension

**Report Dated:**

11-19-2012 through 11-23-2012

Kanwar V. M. Mendiratta, MD
Southfield, MI
43-01-041292
11/20/2012
Summary Suspension
Dissolved

**Report Dated:**

11-26-2012 through 11-30-2012

Robert Kevin Butryn, MD
Traverse City, MI
43-01-064150
01/20/2013
Probation
Fine Imposed
Negligence – Incompetence
Lack of Good Moral Character
Mark Joseph Heinzelmann, MD
Saginaw, MI
43-01-046103
11/21/2012
Fine Imposed
Violation of General Duty/Negligence
Peter R. Nwoke, MD
Grosse Pointe Woods, MI
43-01-082666
11/27/2012
Summary Suspension
Dissolved

**Report Dated:**

11-20-2012

Kanwar V. M. Mendiratta, MD
Southfield, MI
43-01-091134
11/21/2012
Fine Imposed
Violation of General Duty/Negligence
John H. Roberts, MD
Grosse Pointe Farms, MI
43-01-027104
11/21/2012
Voluntarily Surrendered
Failure to Meet Cont. Ed. Requirements
Sameh G. Sawires, MD
Temecula, CA
43-01-093586
12/21/2012
Fine Imposed
Sister State Disciplinary Action
Jack W. Wagner, MD
Midland, MI
43-01-041291
11/21/2012
Fine Imposed
Reprimanded
Violation of General Duty/Negligence

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**Explanation of Disciplinary Terms**

**Board Order** – the legal document that is issued by the Department, on behalf of the Board, which describes the sections of the Public Health Code that have been violated and the discipline that has been imposed for the violation(s).

**Limitation** – a restriction or condition imposed on a licensee by the Board for a specified period of time such as:
- confinement of practice to a location
- supervision of practice – either on-site or periodic review by Board or other Board approved licensee
- restriction of practice to specific activities
- no access to controlled substances
- no ownership or financial interest other restrictions or conditions deemed appropriate.

**Notice of Intent to Deny** – formal document that indicates the Department intends to deny the issuance of a license because of violations of the Public Health Code, past or current.

**Probation** – a disciplinary action in which the licensee’s practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:
- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.

**Reinstate** – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.

**Reimand** – the written statement of rebuke from the Board that a specific activity of the licensee was a violation of the accepted standards of practice.

**Revocation** – a licensee can not practice for a minimum period of three years; if the violation involved controlled substances, the licensee can not practice for a minimum of five years.

**Suspension** – a licensee can not practice for a specified period of time.

**Summary Suspension** – if the actions a licensee is considered a threat to the public’s health and safety, the right to practice can be withdrawn immediately. The Summary Suspension orders the licensee to stop practicing immediately upon receipt of the summary. The summary is hand-delivered to the licensee.

**Summary Suspension Dissolved** – the summary suspension has been removed after an administrative review and the licensee is either allowed to practice or is subject to other disciplinary actions imposed by the Board.

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Cindil Whitney –
Recruitment Administration Office
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Three Rivers
MI 49093

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When I was installed as president of our outstanding organization, I started my inaugural address talking about two of my children who followed my footsteps into the practice of medicine.

I mentioned that they went into medicine for the same reasons you and I did: to help people and make a difference in their lives. But there is no doubt that times are changing in health care with the advent of health care reform, ACOs, larger group practices, PO/PHO models, bundled payments, the trend toward employment, and other recent developments.

No matter the setting and despite the changes in reimbursement models, the foundation – the very heart of the practice of medicine – is and will always be the sacred doctor-patient relationship. In this complex era of change, it’s what we must protect most.

These days I worry about the future for my children in their chosen field. I worry about health care insurance companies directing patient care. I worry about government picking winners and losers in health care through arcane reimbursement processes. I worry that patients don’t have transparency in health care costs so they know upfront what a certain visit or procedure will cost them, or what it will cost their insurer, or Medicare or Medicaid. I worry that health care costs won’t be controlled until we help our patients become full partners in their care, taking responsibility for maintaining their own health through lifestyle choices, chronic care maintenance, and other individual responsibilities.

Obviously, addressing these concerns will require steadfast and enduring efforts of all physicians, regardless of their practice setting. And as noted, practice settings are definitely changing. A 2011 study by the consulting firm Accenture found that physician employment by health systems in the US has been growing an average of five percent per year over the past few years, and in 2013, less than one-third of physicians will be in independent practices.

Not surprising, the same is true on the state level. More and more MSMS members are practicing in an employed situation. The beauty of MSMS and organized medicine is that it works for all physicians, no matter the practice setting. Our recent tort reform wins and Michigan Supreme Court wins and other 2012 legislative accomplishments affect all Michigan physicians and their patients, no matter how or where the physician practices. Additionally, our outstanding MSMS educational resources are tailored to help members in any practice setting with the information they need to succeed in their practices. We must continue to work together through organized medicine for what is best for the practice of medicine because what is best for medicine tends to be what is best for our patients.

If we physicians focus on protecting and preserving the sanctity of the doctor-patient relationship in this era of great change, no matter the practice setting, we will preserve and protect our profession for the generations of physicians who follow us, including my children. And for that, I thank you. 

**Doctor Bizon, a Calhoun County otolaryngologist, is President of the Michigan State Medical Society.**
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