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Michigan Medicine

July/August 2014 • Volume 113 • Number 4

COVER STORY

8 Hospital Consolidations: the Bottom Line for Physicians
By Pamela Lewis Dolan
In 2013, there were 84 hospital mergers and acquisitions nationally. The number of deals was slightly down from the previous year, but the number of hospitals and beds involved in those deals hit a five-year high, according to a May report by Irving Levin Associates, a market research firm based in Norwalk, Conn. The Affordable Care Act is the likely catalyst for the merger and acquisition activity, which is not expected to slow anytime soon.

FEATURES

12 Voice of Medicine Heard in State Budget Process
By Andrew R. Schepers
The voices of Michigan physicians were heard in the 2015 state budget battle that recently took place at the Capitol in Lansing. In a process that started in February, MSMS was crucial in the passage of the budget for the coming fiscal year.

14 Why Physicians Should Run for Political Office …and How to Get Started
By Nick DeLeeuw
With a breadth of practical patient care experience, leadership skills honed over years of training and practice, and proven commitments to public service, Michigan physicians are tailor-made for holding public office – and delivering real results.

18 Active vs Passive Investing – Which is Better for You?
By Nathan Mersereau, CFP, AAMS
How do you make sensible investing choices when there are so many options? Let's take a look at two basic approaches to investing – Active vs Passive management – to help you better understand what is best for you.

19 Northern Physician Organization, MSMS Group Member, Launches Physician-Led ACO
By Joseph M. Neller
With the recent launch of Northern Michigan Health Network, Northern Physician Organization hopes to become a model for the nation in providing physician-led, coordinated and high quality health care.

COLUMNS

4 Ask Our Lawyer By Daniel J. Schulte, JD
Closing Your Practice: Medical Record Retention, Storage and Destruction

6 Professional Liability Update Contributed by The Doctors Company
Rising Number of Infectious Disease Cases Creates Patient Safety Issues

7 HIT Corner By Dara J. Barrera
What Now? The New Proposed Rule Change for Stage 2 Meaningful Use

18 Legal Alert By Patrick J. Haddad, JD
Electronic Prescribing for Controlled Substances

20 MDCH Update From the Michigan Department of Community Health
Influenza – Looking Back, Looking Forward, and Looking for Ways to Improve

22 Medical Family Matters By Nancy Fody
Reducing Michigan's High Rate of Unvaccinated Children

28 President’s Perspective By James D. Grant, MD
Changing Health Care World Needs Our Voice

DEPARTMENTS

18 Obituaries
22 New MSMS Members
23 MSMS Foundation Conferences
24 The Marketplace

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QUESTION:
I have been preparing to close my medical practice for some time. I stopped taking new patients some time ago and have slowed down. I do not think I will attempt a sale. Instead, I plan to retain the medical records I must and destroy the rest. What legal requirements are there that I should be aware of in this process?

ANSWER:
Since you do not intend to sell your practice you mainly need to be concerned with complying with the medical record retention, storage and destruction provisions of HIPAA and Michigan law. You should notify your patients of the closing of your practice. Those patients you are actively treating will likely request a transfer of their records to another physician (you may be asked for a referral). When you receive a transfer request you can either: (1) provide the original record to the patient or the other physician; or (2) maintain the original record and provide a copy. If you decide to have a copy made you may charge the patient a fee for production of the copy. The amount you may charge is limited to those amounts in Michigan’s Medical Records Access Act (these amounts change annually and can be found at www.michigan.gov/mdch/2014_medical_record_access_fee_446641_7.pdf).

Michigan law requires that medical records be retained for at least seven years unless a longer retention period is required by another law or “generally accepted standards of medical practice.” Once medical records are more than seven years old you may destroy them.

Medical records you are required to retain must be protected and maintained by you personally or with a person or entity agreeing to store them on your behalf. If you contract with another for storage of the medical records you must ensure that the contract is in writing and provides for the protection and maintenance of the records in accordance with applicable law and that the storage facility will provide access to the medical records upon your request. No matter who maintains the medical records it must be done in a secure and confidential manner.

The temptation is to destroy all records once they are more than seven years old or to transfer them when the patient requests without retaining a copy. Prior to doing so you must consider the statute of limitations on potential claims for medical malpractice. Generally the statute of limitations is two years from the date of service or within six months after the patient discovers or should have discovered the existence of the claim whichever is later. In most cases, the longest the statute of limitations remains open is six years from the date of service no matter when the existence of the claim was or could have been discovered. Generally then, the statute of limitations will expire within the seven year minimum retention period. However there are statutory exceptions which lengthen the statute of limitations on medical malpractice claims. A discussion of these exceptions is beyond the scope of this column. However, note that medical malpractice claims of minor patients many times extend beyond the seven year minimum record retention period. You do not want to be faced with a medical malpractice claim without the medical records to use in defending yourself.

Once the medical records are more than seven years old and you are satisfied that the statute of limitations has expired you may destroy them. The destruction must be by shredding, incinerating, electronically deleting (consult a computer expert when destroying electronic records) or otherwise disposing of the medical record in a manner that ensures the continued confidentiality of the medical and personal information of the patient. You should not under any circumstances dispose of medical records by putting them in the trash.

Finally, Michigan law requires you to send a written notice to the Department of Community Health when closing your practice. The notice must specify who will have custody of your medical records and how patients may request access to or obtain copies of the medical records. This notice must be sent to: Michigan Department of Community Health, Bureau of Health Professional – Workforce Development, Attention: Perry Bell, P.O. Box 30670, Lansing, Michigan 48909.

Daniel J. Schulte, JD, MSMS Legal Counsel, is a member of Kerr, Russell and Weber, PLC.

EDITOR’S NOTE:
If you have legal questions you would like answered by MSMS legal counsel in this column, send them to: Rebecca Blake, Michigan Medicine, MSMS, 120 West Saginaw Street, East Lansing, MI 48823, or at rblake@msms.org.
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Rising Number of Infectious Disease Cases Creates Patient Safety Issues

Contributed by The Doctors Company

Physicians are reporting communicable, or infectious, diseases that were thought to have been controlled in the United States. New cases of whooping cough (pertussis) and, most recently, measles (rubeola) are making headlines. During the first half of 2014, there were more reported cases of measles than for any year since the disease was eliminated from the country in 2000. In addition, newly classified infectious diseases are emerging, like Middle East Respiratory Syndrome.

To protect staff and patients, medical offices need to have established protocols that limit the exposure risk from individuals who come into the office with one of these debilitating, if not fatal, conditions. Medical malpractice liability risk may grow as reports of infectious diseases continue.

Your practice can reduce liability risks and promote patient safety by:

- Documenting all discussions with patients and parents of minors regarding infectious diseases, including the risks and benefits of inoculation.
- Documenting all discussions about serologic evaluations with patients who are unsure of their immunity status.
- Ensuring that all immunization tracking is up to date so that patients remain on a timely immunization schedule.
- When possible, allowing only staff members who have demonstrated evidence of immunity to work with patients suspected of having a communicable or infectious disease.
- Complying with state laws for the provision of vaccines to healthcare workers. For more information, go to http://www2a.cdc.gov/nip/statevaccapp/statevaccsapp/default.asp.
- Notifying those who may have come in contact with an infected individual that they should see a physician.
- Ensuring that all office staff members are trained in the use of personal protective equipment and on proper isolation techniques when working with patients who present with symptoms of an infectious disease.

Follow these tips if you or your staff suspects a patient has an infectious disease:

- Minimize risk of exposure by moving the patient from the waiting area and isolating him or her in an exam room.
- For airborne diseases, place a surgical mask on the patient and ensure that all office staff members who have demonstrated protective equipment, including gloves, eye protection, masks, or an N-95 particulate respirator, if needed.
- Follow standard disinfection and sterilization procedures for exam rooms.
- Report suspected cases to the local health department and obtain specimens for disease testing.
- Consider making post-exposure prophylaxis available to those who have been exposed.

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.

Participation in Stage 2 of the electronic health records program seems to be on hold as everyone is collectively holding their breath waiting for the final word on the proposed rule change. Many physicians and other eligible professionals are still having problems with Stage 1, and vendors are not fully prepared for Stage 2, so the federal government is proposing some changes.

In December 2013, the Centers for Medicare and Medicaid Services (CMS) announced it would add a third year to Stage 2 in 2016 and delay the start of Stage 3 to 2017. The new proposed changes would also make that a formal part of the rule. The new proposed rule would offer flexibility in using meaningful use criteria from 2011, 2013 and 2014 to attest for Stages 1 or 2 in 2014 for the Medicare incentive program only. Basically, if a physician can't fully implement 2014 criteria in 2014, they can attest using 2011 criteria that includes enhanced criteria under a 2013 upgrade of 2011. (see chart)

The new proposed rule acknowledges that many software vendors have had difficulty making changes to their EHR products, getting the products certified and then getting customers upgraded under the timeline for Stage 2 attestation. The proposed changes would be in effect for the 2014 reporting year only. Physicians would be able to use 2011 Edition CEHRT for either Stage 1 or Stage 2, would have the option to attest to the 2013 definition of meaningful use core and menu objectives, and use the 2013 definition CQMs. These proposed changes are for physicians and other eligible professionals that could not fully implement 2014 Edition CEHRT to meet meaningful use in an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

Most physicians are wondering where to go from here. The time for comments ends on July 21, 2014, so there is hope that any changes to the proposed rule will be minimal and support more physicians who are trying to attest to any of the new scenarios open to them.

The best recommendation is to continue on with your path to achieving Stage 2 criteria. These changes are only effective for the 2014 reporting year, and you will need to be able to perform Stage 2 objectives in 2015. For more information and an interactive tool to assist you in determining your 2014 attestation path, visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CEHRT_NPRM_DecisionTool-.pdf.

The Michigan State Medical Society is here to help with MSMS HIT Consulting Services. MSMS consulting is designed to assist physicians in any specialty or practice size to achieve Meaningful Use, and has staff available to assist you. For more information, contact Dara Barrera at 517-336-5770 or dbarrera@msms.org. MM

The author is the Manager of Practice Management and Health Information Technology at MSMS.

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Hospital Consolidations: the Bottom Line for Physicians

By Pamela Lewis Dolan

Over the past four years, hospital consolidation has reached levels not seen for more than a decade.

In 2013, there were 84 hospital mergers and acquisitions nationally. The number of deals was slightly down from the previous year, but the number of hospitals and beds involved in those deals hit a five-year high, according to a May report by Irving Levin Associates, a market research firm based in Norwalk, Conn. The Affordable Care Act is the likely catalyst for the merger and acquisition activity, which is not expected to slow anytime soon.

“Consolidation has been one of the industry’s go-to responses each time major changes occur,” said Tom Janda, Executive Director of West Michigan Physicians Network (WMPN), “an independent physician organization serving doctors in the western part of the state. We’ve seen it with hospitals, insurers and, to a lesser extent, with physician groups.”

There was a consolidation boom in the 1990s, for example, as a result of the move toward managed care. So it stands to reason that ACA-initiated objectives aimed at increasing efficiencies and reducing health care spending would prompt the latest round of merger and acquisition activity.

On one hand, consolidation addresses the challenges many health care organizations face with care coordination, which has been blamed for poor quality and efficiency in health care. On the other hand, it can create health care behemoths that have been blamed for rising health care costs and a decline in quality because of the lack of competition and transparency.

What’s new with the current round of consolidations, according to Janda, is that many involve systems from disparate markets, such as the 2013 merger between Livonia, Mich.-based Trinity Health and Pennsylvania-based Catholic Health East, which now serves patients in 21 states. These alignments go beyond coordination of care and services to a given community, and often are driven by efforts to gain efficiencies through economies of scale, access capital, and sharing of resources and capabilities around population health.

Nonprofit hospitals are also representing a larger chunk of merger activity, which used to be driven almost exclusively by the for-profit market, according to a March 2012 report by Juniper Advisory, a Chicago-based investment bank that works exclusively with hospitals and health systems.

The deal garnering the most recent attention in Michigan is the Beaumont Health System, Botsford Health Care and Oakwood Healthcare merger announced in June.

Under the signed agreement, the three organizations will combine into a $3.8 billion health care organization called Beaumont Health. The system will include eight hospitals and 153 outpatient sites.

Beaumont had been searching for partnership opportunities since about 2008, according to Betty Chu, MD, MBA, an obstetric/gynecologist and Chief Medical Officer and Vice President of Medical Affairs at Henry Ford Medical Center, who at that time was President of the medical staff at Beaumont. Doctor Chu served on a committee tasked with identifying merger opportunities for Beaumont.

“Beaumont, like every other health care system was challenged in 2008 and 2009,” Doctor Chu said. “And with the implementation of the Affordable Care Act, recognizing that health care was changing — and then, of course, looking at the landscape in Michigan and across the country, and the consolidation that’s occurring in the industry — it was clear to the board that the status quo was not acceptable, that staying as a health system in about the $2 billion to $3 billion range was not going to be enough to maintain a margin in the future.”

“I think, like a lot of hospitals right now, looking at the viability for the next five to 10 to 20 years, as a board of directors, it was clear that we needed to start looking around,” she said.

The hospital system signed a letter of intent with the Henry Ford Health System in October 2012. By May of the following year, the deal was called off due to what Doctor Chu described as difficulty combining two distinctly different cultures. One major difference is that the majority of Beaumont physicians are independent and Henry Ford has historically had an employed model.

David Wood, MD, Chief Medical Officer at Beaumont, said physicians weren’t against the merger with Henry Ford, as had been reported at the time. They just had a lot of unanswered questions.

Physicians, both employed and independent, are very excited about the newly announced merger, according to Doctor Wood. He said unlike the market the Henry Ford deal would have created, there is very little overlap of service areas. Instead of a competitive relationship, the merger will create a collaborative one that will lead to better outcomes and lower overall health care spending, he said.

Impact on Physicians

Many of the industry changes that are leading to merger discussions among hospital systems are also the root of stress for physicians, both employed and independent. They are being forced to do more with less, and to adapt to new care models, new payment models and regulatory pressures that didn’t exist prior to the ACA. When consolidation is added to the equation, the anxiety level rises, according to Doctor Chu.

During consolidation, employed physicians are, understandably, concerned about what it will mean for their departments. The logistics of how two similar departments will be blended into one can be a stressful thing to think about, she said.

There are also a lot of small things that add up: possibly changing the electronic health record systems and the training that will be needed, changing signs outside to reflect the new name, changing phone numbers, and many other details. Physicians have to manage all of those changes while attempting to maintain good patient care.

Doctor Chu, who holds an MBA from the University of Michigan,
said she dealt with several mergers across various industries in business school, but when it comes to health care, it’s a completely different dynamic. “When your product is the care of a patient, it becomes much more complicated than the merging of two businesses whose products are widgets,” she said.

“Your end product is getting the patient through and giving them excellent care. And that will be disrupted any time you merge, it has to. In the process of change, there has to be disruption,” she said.

Doctor Wood said the biggest challenge he anticipates through the Beaumont merger will be getting all eight hospitals and ambulatory centers working together on a common path. But once those challenges are overcome, the system will be able to offer a large cohort of patients across a large demographic area with comprehensive care that is coordinated, high quality and at a decreased cost, he said.

As an independent physician in a market that includes two large systems, Spectrum Health and Trinity, Jon Curry, MD, a Grand Rapids urologist, said two of the biggest challenges he faces are recruitment and maintaining referrals.

When independent practices want to hire new physicians, they can’t compete with the salaries offered by the large hospital systems, Doctor Curry said. If he were to hire a physician out of residency, it would take some time for that physician to build up a patient base and start generating revenue. Independent practices have the desire and ability to grow, but a harder time attracting candidates, he said.

“And in a market where specialists are competing for referrals, the more primary care doctors who are employed, the more referrals go to employed specialists. Hospital acquisition of primary care offices has had a more immediate impact on private practices than hospital-to-hospital consolidation,” according to Janda.

However, because the large health care systems tend to be concentrated in urban areas, it’s made it easier for independent physicians to expand into underserved, rural areas, where the competition isn’t as stiff, Doctor Curry said. His practice has experienced significant growth over the past five years as a result.

Another advantage is that, when given a choice, many patients prefer the intimacy of a smaller, independent practice over a large health care system, according to Doctor Curry. “I have seen patients who come to us because they feel frustrated at the lack of personal attention they receive in a bigger system and bigger office, where they are unsure if they will see their doctor, another doctor or a [physician assistant] or nurse practitioner.”

Kirk Agerson, MD, a family physician in Grand Rapids and Medical Director of WMFN, said as a family physician, there are always enough patients to keep his practice busy. He agrees there is a clear benefit to the patient experience by being a smaller practice.

“They know everyone in my office and we know them. Some of the people I see I have been seeing for 34 years, so we get to know them well and it’s a more personalized service,” he said.

Doctor Agerson also pointed to difficulty recruiting new physicians as the most negative impact from the increased consolidation going on around him.

**Do Consolidations Deliver on Their Promises?**

Consolidations are often presented as a way of gaining higher quality, more efficient care, said Andrea Caballero, program director for Catalyst for Payment Reform, a non-profit aimed at improving value in the health care system. “But the proof is do you really deliver that higher quality, more efficient care at the end of the day?”

“More often than not, when you have consolidation of systems or consolidation of medical groups, prices are going to increase,” she said.
In a 2013 action brief, The Catalyst for Payment Reform referred to consolidation as a major driver of price increases. There hasn’t been a shortage of studies and opinions to bolster this claim.

There have also been studies demonstrating benefits to consolidation including a September 2013 report by the Center for Healthcare Economics and Policy, a subsidiary of FTI consulting, which found of 607 hospitals involved with a consolidation between 2007 and 2013, all but 22 were in areas with at least five independent hospitals. And of those 22, nine were small hospitals with 50 or fewer beds. These are hospitals that likely would have struggled and possibly closed without a partner to provide essential capital and expertise. These findings, the authors say, support the theory that consolidation has been good for some communities.

A 2012 report from the Robert Wood Johnson Foundation found mixed results. It found that consolidation led to higher quality. The report also noted that consolidation in highly concentrated markets led to increased prices that can exceed 20 percent.

“Tender to these general statements made that the economic research uniformly or systematically supports the conclusion that any and all mergers, or mergers particularly in concentrated markets, leads to anti-competitive price increases and that as a result we should be very concerned to see more consolidation occurring,” said Margaret Guerin-Calvert, Senior Managing Director – President, Center for Healthcare Economics and Policy at FTI Consulting. But, underlying studies don’t really support that conclusion, she said.

Many studies also don’t take into account underlying market conditions or even benefits of consolidation, according to Guerin-Calvert. She said studies looking at very specific markets are often used to support broad statements. Another problem is that many of the studies use outdated data from a time when the health care environment was much different than it is today.

Guerin-Calvert agrees the potential exists for highly concentrated consolidation to lead to higher prices. “That is the crux of what FTC enforcement is all about,” she said.

The Federal Trade Commission has the authority to put the brakes on any merger deal it deems to be in violation of antitrust laws. In recent years, it has expressed concern that the rise in hospital mergers – among both nonprofit and for-profit systems – will create noncompetitive markets that will result in consumers paying more for services.

There’s evidence the FTC is ramping up its authoritative power. Historically, about five percent of transactions announced through letters of intent do not close. But in 2011, 25 percent of mergers announced through letters of intent did not materialize, according to a 2013 study by the CPA firm of Dixon Hughes Goodman. St. Luke’s Health System in Idaho was ordered by a federal judge in January to dissolve its 2012 merger with Saltzer Medical Group after the FTC sued, saying the merger created an anti-competitive market that would lead to higher prices for consumers.

The American Medical Association filed an amicus brief in a similar case, Federal Trade Commission v. Phoebe Putney Health System, that made it to the U.S. Supreme Court in 2012. In it, the AMA wrote: “Anticompetitive mergers and acquisitions by public hospitals may undermine the ability of physicians to provide the care that their patients deserve. These transactions can compromise the ability of physicians to provide high quality care at hospitals – and to refer their patients for such care – because the absence of competition allows the dominant hospital to increase the prices it charges and to lower the quality of care it provides to patients.”
Doctor Chu said the success of consolidations will depend on the motivations driving them.

“We have to get scale in order to improve and do the things we want to do. A lot of consolidations, I think, are being driven on, ‘we have to get more scale to be more profitable,’ which is a really different message.”

**Alternatives to Traditional Consolidation**

Many health care systems are pointing to consolidation as the only way they can deliver the level of coordinated care being mandated in the post-ACA world. “I think that’s a little bit of misconstruing of what’s happening,” said Shaudi Bazzaz, program manager for Catalyst for Payment Reform. “Consolidation doesn’t equal coordination,” she said. “You can coordinate care and deliver coordinated care without necessarily consolidating.”

One way is through the creation of clinically-integrated networks.

One example is the creation of Together Health, announced in May. Physician groups from Trinity Health and Ascension Health joined forces to form the physician-led integrated network. It is not a merger in the traditional sense of combining assets. Both systems contribute equally to the new company that will negotiate managed care contracts for the participating 27 hospitals and hundreds of ambulatory centers and physician offices.

The partnership will help participating physicians achieve good coordination without all of the issues that come along with traditional consolidation, said Scott Eathorne, MD, a family physician and interim CEO of Together Health. Physicians will have the advantage of shared resources such as health IT support, data analytics, decision support and utilization management to help achieve success in a pay-for-value environment, he said.

WMPN, which represents 550 physicians in the western portion of the state, is also exploring ways to achieve care coordination goals outside of consolidation or, in the physicians’ cases, becoming employed by these consolidated systems.

“Payment systems are going to be based on quality of care and efficiency of care rather than just the number of patients you see in the office or the number of procedures you do,” said Doctor Curry, the Grand Rapids urologist who is also President of WMPN. “In order to provide the most effective care and best experience for the patient, we need to find better ways for private practice physicians, employed physicians, and hospitals to work together.”

Doctor Curry said his group has felt the pressure to become employed in the increasingly consolidated market. Despite repeated offers from various health systems in the area, he remains committed to being independent, he said. He remains hopeful that physicians can work together to create a clinically-integrated network in his community.

“Good or bad, the results of consolidation are likely to stick for many years. Therefore it’s important for physicians to be involved in the process,” said Doctor Chu.

“If I had to give my take-home message it would be: it’s going to increase anxiety, but physicians absolutely need to be a part of the leadership structure of any consolidation,” she said. “Physicians are really the only people who can understand the complexities of inpatient and outpatient medicine well enough to make these consolidations successful.”

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The author is a Oak Lawn, Illinois-based freelance writer.
Voice of Medicine Heard in State Budget Process
By Andrew R. Schepers

The voices of Michigan physicians were heard in the 2015 state budget battle that recently took place at the Capitol in Lansing. In a process that started in February, MSMS was crucial in the passage of the budget for the coming fiscal year.

Questions surrounded lawmakers about where they would find replacement revenue for the loss of Medicaid dollars for primary care services, potential cuts to Michigan’s graduate medical education program and how to expand primary care into underserved and rural areas. These are all issues that physicians had a hand in solving.

Senator Roger Kahn, MD, chair of the Senate Appropriations Committee who was in his last budget battle as a physician-legislator, said he was happy how this budget turned out. “I am proud of the work that went into making this budget a responsible use of the tax payer dollars.”

This year’s budget was approximately $18.2 billion with just over $3 billion from the General Fund of the state. Healthy Michigan was the focal point for legislators at the start of the budget process. They wanted to ensure that funding for the program would be available and the state was ready to take on new Medicaid enrollees. Healthy Michigan received just over $2.4 billion in federal support with the state kicking in restricted dollars in the $20 million range. With the realization of funding for the program from the federal government and with the addition of restricted dollars, the state was able to save $248 million in General Fund dollars.

Medicaid, as a whole, also saw an increase in its funding for the coming year. The changes to the reimbursement rate in the Medicaid program brought an increase of $79.3 million for the coming fiscal year. The Governor, along with the Legislature, sees greater utilization of the program and the slight increase in the funding supported that assumption.

Primary care physicians did make it out of the budget process somewhat unscathed. The Affordable Care Act provided increases for primary care Medicaid reimbursement to those comparable to Medicare; rates that MSMS fought to keep. At the end of the calendar year, Michigan physicians had a hand in ensuring that the state’s budget was responsible and that the funding for primary care services was maintained.

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year, the funding for those rates will expire, bringing the rates back to the 65.65 percent rates in Medicaid. The Legislature agreed with MSMS and wanted to continue to support the investment in primary care and added $25 million to cover 50 percent of the lost federal revenue starting after January 1, 2015.

Obstetricians also received a boost in funding by the Senate with their attempt to raise their rates to 100 percent of Medicare. “This is a step in the right direction for the state,” said Doctor Cheryl Gibson-Fountain, an obstetrician/gynecologist from Wayne County and an MSMS Board member.

Focusing on primary care led to Graduate Medical Education (GME), as a topic of discussion for the Appropriations Subcommittee. Questions about quality and return on investment continued to dominate debate. The Governor this year had recommended to the Legislature that the one-time funding for Graduate Medical Education be removed. However, MSMS once again created a campaign to restore the funding cut recommended by the Governor. Doctor Kenneth Elmassian and forth-year medical student Christopher Wee testified to the Senate Appropriations Subcommittee on the importance of the program and the impact that it has.

After hearing the testimony from MSMS and the calls and e-mails from physicians and medical students all around Michigan, the subcommittees had a different take than the Governor. The House recommended that only half of the one-time funding be reinstated, leaving the program short by $1.4 million. The Senate had other plans and restored the cut from the Governor and made the funding ongoing rather than one-time funding. Support from the chairs of the committee never wavered and the program was funded at the Senate levels and they made the funding ongoing, leaving it potentially harder to cut in the future. For the coming fiscal year Graduate Medical Education will receive almost $163 million with $55 million coming from the General Fund.

The ongoing funding for GME hopefully will provide some stability to the program, but it did not answer the questions of program transparency and how to place more residents into primary care positions.

The partial answer to these questions is the MiDocs program. MiDocs is a consortium with the state of Michigan and the Michigan-based medical schools to develop a freestanding residency training program that focuses on primary care and helps address shortage areas in the state. The second funding solution was a group of bills that coincided with the budget that strengthened the loan repayment program in Michigan. Senator John Moolenaar, Republican from Midland, introduced legislation that would expand the loan repayment program to provide incentives to those young physicians who choose to work in underserved and rural areas in Michigan. The House and Senate agreed to add an additional $500,000 in General Fund revenue to the program and add an additional $600,000 in private revenue, bringing the total to $1.1 million in additional dollars for the program.

“Overall, this state budget process was another victory for Michigan physicians and our patients,” said Michigan State Medical Society president James Grant, MD. “The combination of physicians using their voices to speak up for the profession and patients and the forward thinking of the Legislature and the Governor, will move us toward a better future for medicine in Michigan.”

The Legislature now has left for the summer recess and is due back in September. MM

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The author is Chief, Grassroots Development & Legislative Policy, at MSMS.
Why Physicians Should Run for Political Office …and How to Get Started

“Lansing just doesn’t get it!” “What were lawmakers thinking?” “Why don’t the politicians ever ask a physician?”

By Nick DeLeeuw

For physicians who live and breathe patient care and who function every day on the frontlines of health policy, these can be easy phrases to shout at the television news or murmur into the newspaper.

From local town halls to Lansing – and all the way to Washington, D.C. – politicians and policymakers are debating health care issues each and every day. For patients and physicians alike, the stakes couldn’t be higher. Unfortunately, Michigan currently has only a few physicians at the table as critical policy decisions are made.

Instead of shouting in exasperation at the local news, there may be another question altogether that’s worth asking – “Is there something I can do about it?” Or perhaps more bluntly, “Should I run for office?”

With a breadth of practical patient care experience, leadership skills honed over years of training and practice, and proven commitments to public service, Michigan physicians are tailor-made for holding public office – and delivering real results.

Michigan has a great tradition of physicians who have held elected positions and used them to improve the lives of patients across the state. Physicians like former Congressman Joe Schwarz, former state Senator Tom George, and former state Representative Jimmy Womack were champions for sound health care policy during their times in office. Congressman Dan Benishek, a physician in the Upper Peninsula, and state Senator Roger Kahn, a Saginaw-area physician, serve as powerful advocates for Michigan patients today.

Unfortunately, term limits prevent many of these leaders from seeking another term in office at a time of incredible change in health care, when physicians’ unique voices and experiences are needed the most.

With lawmakers in Michigan and nationally poised to discuss everything from scope of practice changes to Medicaid expansion, decreasing immunization rates and outbreaks of preventable infectious diseases, and changes to the recent national health care mandate, no one is better suited to speak for patients and for physicians than physicians themselves.

So Where – and How – Does a Physician Get Started on a Path to Public Service?

While the filing deadline has come and gone to run for office in 2014 (see our sidebar to learn about several highly qualified Michigan physicians on the ballot this year), now is the perfect time to contemplate and begin taking the first steps toward a possible run for office in 2016.
Different political offices have different candidacy requirements, but a few general guidelines may help as physicians contemplate public service:

- **Talk to your spouse and family.** While only one name appears on a ballot, a run for public office is always a family affair. Campaigns require a great deal of sacrifice and understanding from the entire family. And a win at the ballot box will mean lifestyle changes for years to come. These are major family issues, and being on the same page is a critical first step towards a successful candidacy.

- **Decide what you want to run for, and when.** Every two years, each seat in the state House of Representatives is up for grabs, along with each of the 14 seats in Michigan’s Congressional delegation. Michigan’s state Senate seats will not be on the ballot again until 2018.

- **Mark your calendar.** Visit Michigan’s Bureau of Elections online to learn about all of the state’s important filing dates. If you don’t take the necessary steps to meet filing deadlines and requirements, your name won’t appear on the ballot.

- **Consider attending a “campaign school.”** The American Medical Political Action Committee (AMPAC), the Michigan Republican and Democratic parties, as well as numerous nonpartisan organizations, routinely offer campaign schools for legislative candidates. Learning the ropes of a campaign from political professionals could make all the difference in your race.

- **Meet with your caucus campaign team.** If you are running for a seat in the state legislature, both the Republican and Democratic caucuses have legislative campaign teams that exist specifically to provide campaign training and to help you campaign effectively.

- **Contact the Michigan State Medical Society and the American Medical Association.** Both MSMS and the AMA offer experience, resources, and expertise that can help you in your run for office.

- **New shoes.** The most important thing a candidate for office can do during a campaign is to personally knock on residents’ doors, asking for votes. Invest in a few pairs of new, comfortable walking shoes. You’re going to need them!

With the future of patient care on the line, Lansing and Washington, D.C. both desperately need to call a doctor. With these tips in mind, it may be time to ask yourself – are you willing to make a house call?

The author is a freelance writer from Lansing, MI.

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**2014 High-Profile Races Featuring Michigan Physicians**

- John Bizon, M.D
  Candidate for state House, 62nd District
  Former President, Michigan State Medical Society

- Jeff Holmes, MD
  Candidate for Congress, 4th District

- Edward J. “Ned” Canfield, DO
  Candidate for state House, 84th District

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Sincerely,
Christopher S. Kim, MD
2014 ASM Planning Committee Chair

2014 HIGHLIGHTS

- Free plenary sessions on Thursday and Friday mornings
- Ten sessions to choose from daily Wednesday – Friday
- Evening sessions with dinner on Wednesday and Thursday
- Free William Beaumont Lecture Luncheon on Friday
- Three Saturday morning courses
- Complimentary breakfast, lunch and breaks

For complete course details including a full conference brochure, visit us at: www.msms.org/asm.

HOTEL INFORMATION

Somerset Inn
2601 W Big Beaver Road, Troy, Michigan
Phone: 248-643-7800
Standard Room Rate: $139 plus tax

CONTINUING MEDICAL EDUCATION

Statement of Accreditation:
The Michigan State Medical Society (MSMS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

AMA Credit Designation Statement:
The MSMS designates this live activity for a maximum of 28.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Nurses:
The ACCME is approved by the Board of Nursing as an acceptable provider of continuing education for license renewal or relicensure.

AAPP Credit:
Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

1. Online at www.msms.org/asm
2. Mail registration form to MSMS Foundation
   120 West Saginaw Street
   East Lansing, MI 48823
3. Fax registration form to 517-336-5797
4. Phone MSMS Registrar at 517-336-7581
October 21–October 25 • Somerset Inn • Troy

Please Print:

Name (first) ____________________________  (initia) ____________________________  (last) ____________________________  (title) ____________________________

Street ____________________________

City ____________________________  State ____________________________  Zip ____________________________  County ____________________________

Phone (include Area Code) ____________________________  Fax ____________________________

Email Address ____________________________

CHOOSING YOUR COURSES: Please check one morning, afternoon and/or evening session you will be attending each day.

Wednesday, October 22

All morning courses run concurrently from 8:30 am to 12:00 pm
☐ Medicare Part D Clinical Star Measures
☐ Attention Deficit Hyperactivity Disorder (ADHD): A Primary Care Update
☐ Women’s Health: Contemporary Perspectives
☐ Updates in Addiction Medicine 2014: Pain and Addiction
☐ Dermatology Update
☐ Wednesday Lunch (Included)

Wednesday, October 23

All morning courses run concurrently from 8:30 am to 12:00 pm
☐ Neurology for the Generalist: The 6th Annual Course for Hospitalists and General Practitioners
☐ Updates in Pulmonary Medicine
☐ Endocrinology and Diabetes Update
☐ From Valves to Shocking Boxes: What you Need to Remember in the Ever-Changing Field of Cardiology
☐ Challenging Surgical Studies

Wednesday, October 24

All morning courses run concurrently from 8:30 am to 12:00 pm
☐ Plenary Session - 7:00-8:00 a.m.
☐ Sew Up the Safety Net for Women and Children: Reducing Infant Mortality in Southeast Michigan Through Equitable Care (included)
☐ Management and Approach to Common Renal issues in the Outpatient Setting
☐ Cardiology Update
☐ Update on Food Allergies
☐ Ophthalmology Pearls for the Primary Care Physician: An Overview from the Experts
☐ Rounding Up the Unusual Suspects: A Look at Unfamiliar Rheumatologic Conditions with Common Features
☐ Friday Lunch / Beaumont Lecture (Included)

Thursday, October 22

All morning courses run concurrently from 8:30 am to 12:00 pm
☐ Pediatric Emergencies: Expecting the Unexpected
☐ Master Series: Medicaid Expansion under the Affordable Care Act - Michigan’s Response
☐ Less is More: Blood Conservation and New Guidelines for Transfusion
☐ Lung Cancer Screening in Context: Myths and Future Directions
☐ Management of Common Spine and Brain Diseases
☐ Thursday Lunch (Included)

Thursday, October 23

All afternoon courses run concurrently from 1:30 pm to 5:00 pm
☐ What Works and What Doesn’t: AOEM’s Practice Guidelines: Focusing on Chronic Opioid Treatment and AOEM’s Choosing Wisely List
☐ Infectious Disease Update 2014
☐ Update on the Treatment of Venous Disease
☐ Radiology Update
☐ Updates in Colorectal and Fecal Screening

Thursday, October 24

All morning courses run concurrently from 8:30 am to 12:00 pm
☐ Plenary Session - 7:00-8:00 a.m.
☐ HIPAA Security Law
☐ Urology for the Non-Urologist
☐ An Update in Endovascular Management of Cerebrovascular Pathology
☐ Obstructive Sleep Apnea: Public Health, Health Consequences, Evaluation and Management
☐ How to Evaluate the Adult and Adolescent Patient Complaining of Headaches Amidst Other Problems

Friday, October 25

All morning courses run concurrently from 8:30 am to 11:00 am
☐ Selected Topics in Otolaryngology for the Primary Care Physician
☐ Back Pain: Red Flags for Serious Disease, Infections, Tumors and Spinal Compression
☐ Interventional Radiology 2014 for Clinicians

YOUR PAYMENT

MSMS Members: $110 per course
MSMS Members with “retired status”: $85 per course
YPS Members: $85 per course
Residents: No fee
Non-Members: $140 per course
Nurses: $110 per course
Students: No fee

Multiply total number of courses by category:

☐ x $110 (MSMS Members) = $__________
☐ x $85 (MSMS Retired and YPS members) = $__________
☐ x $140 (Non-Members) = $__________
☐ x $110 (Nurses) = $__________
☐ x $50 (Students and Residents) = $ - 0 -

SUBTOTAL $__________

TUESDAY’S FEES: Patient Centered Medical Home: Supporting Patients and Population Health
☐ x $160 MSMS Members
☐ x $200 Non-Members
☐ x $50 Students and Residents $ + $__________

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3. Fax registration form to 517-336-5797
4. Phone MSMS Registrar at 517-336-7581

Send this entire page with your payment. Confirmation of your reservation will be mailed to you.
Active vs Passive Investing – Which is Better for You?

By Nathan Mersereau, CFP, AAMS

Have you ever wondered which investing strategy you should choose? Turn on the TV, scan the internet or read the latest financial magazine and you’ll find financial evangelists promoting their sure-fire way to make money. Everyone sounds convincing, but how do you make sensible investing choices when there are so many options? Let’s take a look at two basic approaches to investing – Active vs Passive management – to help you better understand what is best for you.

Active Investing
Active investing is an attempt to “beat the market” as measured by a particular benchmark or index. Rather than investing in a total index, the portfolio may include a number of specific holdings within the index. For example, an investor may set up a strategy to buy and sell stocks within the S&P 500 in an attempt to get better returns than the S&P 500 would on its own. The investor may look at market trends, the economy, current events, the political environment and company-specific factors to make decisions.

While seasoned money managers believe the market can be beaten, successful active investing requires persistent monitoring of the investments as well as awareness of market fluctuations. Active managers admit they can’t beat the market all the time, but they do believe there are irregularities in the market that can help them outperform the index. They also have more control to make changes if they believe the market may take a downturn.

But mistakes may happen. Regardless of the manager’s conviction, they can make unwise choices and in turn reduce returns. Active investing typically results in higher costs – both from frequent trading generating higher fees and tax implications resulting from selling holdings. When investing on your own, abrupt changes in the market may cause impulsive acts due to an emotional response of fear or greed. Because the investor is completely in control of their investments, adjustments to their portfolio are common and easy to execute.

Passive Investing
Passive managers generally believe it is difficult to beat the market. They offer performance that closely matches an index for investors unwilling to take the risks inherent with active management.

Passive investing, sometimes referred to as indexing, is a limited maintenance investment strategy that targets long-term appreciation. Simply by copying an index, such as the S&P 500, a passive investor would purchase stocks in the exact proportions as the S&P 500. Because of this, success through passive investing is parallel to the market’s performance – ebbs and flows within the market affect the entirety of the passive investor’s portfolio. Passive investing requires less decision-making, attention, and maintenance than active investing. Therefore, fees associated with the upkeep of the portfolio are low. Tax implications are usually lower since trading is infrequent.

Passive investors must understand their performance is dictated by the index. They must be satisfied with the returns of the index even during downtrends since the strategy will not take defensive changes proposed by active managers. This requires discipline and patience – two items often lacking with individual investors. But those investors exhibiting these traits are often rewarded; given indexes returns outperform the vast majority of active managers.

Conclusion
While there will be times when one approach will be more beneficial than the other, it may be helpful to consider using both. Each approach has advantages and disadvantages. Try to ignore the trend of the moment, focus on the long-term, evaluate your timeframe and risk tolerance, and stay diversified. Sensible investing doesn’t have to be complicated.

The author is President of WealthCare Advisors, LLC – an MSMS joint venture.

www.wealthcareadvisors.com

OBITUARIES
The members of the Michigan State Medical Society remember with respect their colleagues who have died.

Ahmad N. Azar, MD
Grosse Pointe Shores, Died June 16, 2014, at the age of 80.

Laurence H. Feenstra, MD
Grand Rapids, Died June 25, 2014, at the age of 86.

John M. MacKeigan, MD
West Olive, Died July 28, 2014, at the age of 70.

Nicholas N. Velarde, MD

David L. VerLee, MD
Holland, Died June 3, 2014, at the age of 76.

IN MEMORY
If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, please contact Rebecca Blake, Director, MSMS Foundation, 120 W. Saginaw St., East Lansing, MI 48823, call 517-336-5729 or e-mail rblake@msms.org.
Northern Physician Organization, MSMS Group Member, Launches Physician-Led ACO

By Joseph M. Neller

Northern Physician Organization (NPO) is already working to transform the health care landscape in Michigan and with the recent launch of Northern Michigan Health Network, hopes to become a model for the nation in providing physician-led high quality health care.

As one of the 360 recognized Accountable Care Organizations (ACOs) under the Affordable Care Act’s Medicare Shared Savings Program, Northern Michigan Health Network brings together primary care and specialty physicians across all communities in the northern region of the Lower Peninsula to engage in the delivery of more efficient and effective patient care. The physicians in these communities were willing to accept the responsibility of forming an ACO due to Northern Physician Organizations’ history of strong community engagement and leadership.

“Northern Michigan Health Network really got started over a year ago,” explained NPO Executive Director Marie J. Hooper, RN. “We were looking at how NPO could benefit the areas where we have physicians so it really made sense to reach out to all members of the community, including the hospitals, the colleges and the Chambers of Commerce across the region. It really prepared us to respond to the Medicare application and how every stakeholder will be accountable for the patients in Northern Michigan.”

Northern Michigan Health Network places an emphasis on community engagement of all the key stakeholders in order to ensure the highest level of coordinated health care. By working together at a community level, patients are more likely to receive the right care at the right time and avoid duplication or unnecessary services. While care coordination can improve health, improve patient satisfaction, and reduce the cost of health care, NPO knows the success of Northern Michigan Health Network relies on the strong leadership of its physicians.

“As physicians, we have an understanding of how to deliver health care and how to do it most efficiently,” said NPO President Peter Sneed, MD. “We know the country has run out of money from a health care standpoint, so this system as it’s currently working is not sustainable. There are tremendous inefficiencies in terms of the duplication of tests or services and lack of communication across settings. It all comes back to our belief that physicians should be at the table in a leadership role and when we’re active and involved we know we can do better for patients.”

The history of Northern Physician Organization – an MSMS physician organization member – to align the practices of nearly 500 physicians across the region provided the foundation for Northern Michigan Health Network. Member of the NPO Board of Directors, Nathan March, DO, said the work by NPO to align clinical processes, communications, best practices and ideas have allowed the physicians in the region to assume new levels of accountability for their patients’ health.

“We’re in a unique community where we have physicians who are more progressive and of the mind where they are willing to take some additional risk if they know they are going to get an opportunity to shape and improve patient care,” explained Doctor March, a family physician in Traverse City. “As a result we’ve been able to break down some barriers and silos in care that might not be possible in other areas.”

However, as overwhelming positive as the reception to the new ACO has been, it has not been without apprehension. Some of the physicians in the area were unsure how the new model would affect their practice and how it would be received by patients. In their philosophy of inclusive engagement and physician leadership, NPO leadership reached out to the physicians to be more closely involved in the planning process for Northern Michigan Health Network, according to Doctor March. He says engaging physicians early in the formation was helpful in gaining their support and their support extended to their patients.

“Patients believe in their physicians and when physicians were able to tell patients they were helping to create a new way to improve the care they provide, patients were very excited.”

NPO Executive Director Marie Hooper agreed, saying the level of physician involvement directly is meaningful to patients, “once we share with patients that it’s their physician leading these changes and not the government or the insurance company, there is immediate relief. Patients want their physicians to be leading the charge.”

Through its strong physician leadership and an engaged patient population, NPO believes Northern Michigan Health Network can be among the nation’s most successful ACOs. The program aims to reduce the rate of health care spending for Medicare patients, but NPO says its main focus is to improve the lives of all patients in Northern Michigan.

“This isn’t about making money or bonuses,” said Doctor Sneed. “At the base of it all it’s about taking care of patients and we get into trouble if we ever lose sight of that fact. That’s where physicians need to be involved.”

The author is the Director of Integrated Physician Advocacy at MSMS.
Influenza – Looking Back, Looking Forward, and Looking for Ways to Improve

An Update from the Michigan Department of Community Health

Summer is the time when we reflect on the flu season that recently ended, prepare for the upcoming flu season, and strategize how we can prevent more illnesses with flu vaccination. The Centers for Disease Control and Prevention (CDC) published a summary of 2013-2014 flu activity in the US in the June 6, 2014, issue of Morbidity and Mortality Weekly Report (MMWR).1 Flu activity increased through November and December 2013 and peaked in late December. Overall, 2009, H1N1 viruses predominated during the 2013-2014 flu season. This past flu season was the first since the 2009 pandemic where pH1N1 viruses predominated.

Information on patient visits to health care providers for influenza-like illness (defined as fever ≥100° plus cough and/ or sore throat) is collected through the US Outpatient Influenza-like Illness Surveillance Network (ILINet). Nationally, the weekly percentage of outpatient visits for influenza-like illness (ILI) peaked at 4.6 percent at the end of December and was at or above the national baseline for 15 consecutive weeks. This was lower than the peak during the 2012-2013 season at 6.1 percent. In Michigan, the weekly percentage of outpatient visits for ILI peaked at 3.4 percent at the beginning of January and was at or above the state’s baseline for 17 consecutive weeks.

ILINet is an integral component of influenza surveillance in Michigan and helps inform public health officials when flu activity begins, peaks, and ends. Michigan’s sentinel providers receive free laboratory testing for approximately 11 specimens per season and weekly feedback reports including summaries of regional, state, and national influenza data. Sentinel providers that regularly report through the flu season also receive free registration for two of their staff to attend an MDCH Fall Regional Immunization Conference. If you are interested in becoming a flu sentinel provider and participating in this important surveillance program, please contact Stefanie DeVita, Influenza Epidemiologist, at DeVitaS1@michigan.gov.

During the 2013-2014 flu season, persons aged 18-64 years accounted for 57 percent of reported hospitalizations nationally. Young and middle-aged adults made up a similar proportion of reported hospitalizations in Michigan as well. As of May 17, 2014, there were 96 influenza-associated pediatric deaths reported nationally, 3 of which occurred in Michigan. As of November 2013, an estimated 39.5 percent of people 6 months and older were vaccinated against flu in the US. Final flu coverage estimates will be released soon.

The June 6, 2014, MMWR included information about the formulation of flu vaccine for the next flu season. For the 2014-15 influenza season, flu vaccines will contain the same virus strains as were in the 2013-14 flu vaccines.1

Although flu activity during the summer is typically low, cases of flu are detected in the U.S. throughout the summer. Health care providers should remain vigilant and consider flu as a potential cause of summer respiratory illness. Providers should also consider novel flu virus infections in persons with ILI and swine exposure.

To kick off the 2014-2015 flu vaccination season, make sure to attend MDCH’s 3rd annual flu webinar on August 27. Information about how to register for the flu webinar will be sent to the MDCH Immunization Listserv. If you have questions, please contact Stefanie DeVita at DeVitaS1@michigan.gov.

Make sure to check MDCH’s website for educational materials to use during the 2014-2015 season. Handouts will be posted online as they are updated for the new flu season at www.michigan.gov/flu (click on Current Flu Season Vaccination Materials). You can also find MDCH’s flu vaccination recommendations in the same location. Remember to begin vaccinating your patients as soon as you receive the vaccine in your office and continue to vaccinate throughout the entire flu season until the vaccine expires (typically June 30).

Special Populations & Further Points to Consider

High Risk Flag in MCIR: MDCH would like to remind immunizing providers about the high-risk flag feature in the Michigan Care Improvement Registry (MCIR). Flu vaccination is associated with reductions in illness, hospitalization, and death among persons at high risk for flu complications. In 2005, the high-risk flag was added into MCIR in response to the low flu vaccination rates among children with persistent asthma who were enrolled in Medicaid. The high-risk flag is activated in MCIR by Medicaid claims data which identify children with medical conditions that make them a high priority for flu vaccination and reminds them that flu vaccine should be administrated. The high-risk flag does not indicate in MCIR the health condition that puts the child at risk.

Providers can also flag children who are not enrolled in Medicaid whose medical condition puts them at high risk of complications from flu. This is accomplished by clicking the High Risk edit link located on the General Information page and checking the
Influenza Screening Notification box under High Risk Conditions in MCIR. This identifies those patients that should promptly receive flu vaccination each flu season. Recall notices can be generated for children at increased risk of flu complications by your practice during the flu season. For more information on how to use the high-risk flag, see the MCIR Tip Sheet (www.mcir.org).

The 2-Dose Rule for Some Children: Some children age 6 months through 8 years will require two doses of flu vaccine during the 2014-2015 season to be fully protected. MDCH’s 2-dose algorithm handout will be updated based on the Advisory Committee on Immunization Practice’s (ACIP) 2014-2015 influenza vaccination recommendations.

Vaccinating Pregnant Women: Vaccinating pregnant women against flu protects not only them but their babies as well. Similar to Tdap vaccine, vaccinating a pregnant woman will provide protection to the infant while they are too young to be vaccinated themselves. ACIP’s recommendations for the 2014-15 flu season will be published in MMWR in August or September. Be sure to check the MDCH website (www.michigan.gov/flu) frequently when the 2014-15 flu vaccination recommendations are released for the most up-to-date educational materials available.

Lastly, flu vaccination is a reminder that we work to prevent not just influenza but complications due to influenza, such as pneumonia. When you administer flu vaccine to adults in your practices, it is important to be sure they are up-to-date with all recommended vaccines for adults. The National Foundation for Infectious Diseases has developed new content for its Public Health Resources & Toolkit to support adult pneumococcal disease prevention. The toolkit includes an infographic about adult pneumococcal disease in the US, and other ready-to-use public education materials. The toolkit is posted at: http://adultvaccination.org/ professional-resources/public-health-toolkit.

As the 2014-15 influenza season quickly approaches, stay up-to-date on the recommendations and resources available to help you navigate through the season at www.michigan.gov/flu and www.cdc.gov/flu.

Michigan’s 2014 Annual Immunization Conferences

MDCH is pleased to announce the Annual Immunization Conference series. The online registration process will begin September 5. See www.michigan.gov/immunize > Health Care Professionals/Providers for more information.

**MDCH Fall Conferences**

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Medical Director, Providence Pain Management Center
Board Certified in Anesthesia and Pain Medicine

John H. Traylor, M.D., D.A.A.P.M.
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Member, American Academy of Pain Management

Affiliated with Northland Anesthesia Associates, P.C.
Reducing Michigan’s High Rate of Unvaccinated Children

By Nancy Fody

Vaccinations are making the news all around Michigan these days. The Michigan Department of Community Health Update in May/June 2014 issue of Michigan Medicine was titled “Are Your Adolescent Patients Up to Date on All Recommended Vaccines?” Channel 12 in Mid-Michigan reported about the outbreak in measles and whooping cough as did the Detroit Free Press on National Infant Immunization Week in April. At the Michigan State Medical Society Alliance annual meeting in Muskegon May 2, several Alliance members brought their vaccinations up-to-date. Pat Krehn RN, BSN, a nursing supervisor with the Muskegon County Public Health Department administered Tdap vaccinations to Alliance members, including the incoming AMA Alliance president Sarah Saunders, a guest at the annual meeting. The focus of MSMS Alliance this year is on reducing Michigan’s high rate of unvaccinated children.

According to the Centers for Disease Control & Prevention, Michigan has the fourth highest vaccination exemption rate in the nation. Last year, 5.9 percent of Michigan’s kindergarteners entered school unvaccinated causing an increase in cases of measles and pertussis in Michigan. Of those “opting out”, 0.6 percent for medical reasons and 5.3 percent were for religious or philosophical reasons. Alliance members are concerned about the high rate of parents foregoing vaccinations for philosophical reasons.

Ms. Krehn reported that the majority of waivers in Michigan are signed by highly-educated mothers. These moms learn about vaccinations on the internet rather than from their physicians. MSMSA hopes that by educating parents about vaccinations, the number of unvaccinated children will decrease.

The MSMS Foundation is supporting the Alliance with a grant to be used for immunization projects around the state. The grant will be used by County Alliances to engage in the “Project-in-a-Day” for Immunization Education. Each County Alliance is encouraged to do one project to educate the public about the importance of vaccinations for children and adults. Several projects are already scheduled.

On Saturday, September 13, Muskegon County Medical Society Alliance will host a public forum called “Healthy Bodies, Healthy Minds.” Pat Krehn, RN, BSN, will present on childhood immunizations, Andy Mann, from the Muskegon Area Intermediate School District will discuss cyber bullying and Rich Goltz, MD, from Port City Pediatrics will provide instruction on preventing childhood obesity. The program will run twice between 9:00 and 10:30 am at the downtown Farmers Market. The Muskegon County Alliance plans to videotape the sessions and post them on YouTube for even greater exposure.

The TriCounty Alliance will be presenting “Deciphering the Facts and Myths about Childhood Immunization: A Community Forum” in September with four local physicians speaking.

Kent County Medical Society Alliance is planning an Immunization Forum Tuesday, October 14, focusing on education. The program begins at 9:30 am at the KISD Conference Center. Three speakers will include Mark Hall from the Kent County Health Department, Mimi Emig, MD, an Infectious Disease Specialist at Spectrum Health, and Veronica McNally from the Franny Strong Foundation.

Welcome to These New MSMS Members

Mohammad Ashraf, MD, Genesee
Laurie Dixon, MD, Washtenaw
Peter Emiley, MD, Washtenaw
Kun-Tai Hsu, MD, Ingham
Amanda Kaufman, MD, Washtenaw
Bernard Kemker, MD, Genesee
Andre King, MD, Washtenaw
Rhonda Kobold, DO, Genesee
Marie-Adele Kress, MD, Washtenaw
Matteo LoPiccolo, MD, Washtenaw
Roghieh Maledadeli, MD, Washtenaw
Emily Mills, MD, Washtenaw
Justin Oldfield, MD, Washtenaw
James Olson, MD, Ingham
Jonas Owen, MD, Genesee
RatnaValli Pasupulati, MD, Oakland
Heather Pontasch, MD, Washtenaw
Mary Anne Purtil, MD, Washtenaw
Jennifer Rollenhagen, MD, Kent
Asha Shajahan, MD, Oakland
Rachel Streu, MD, Washtenaw
Nicholas Szerlip, MD, Wayne
Kevin Taylor, MD, Washtenaw
Shelly Temperley, MD, Monroe
Namrata Vashishta, MD, Washtenaw
Xiao Yang, MD, Washtenaw
New MSMS Foundation Educational Conferences

**New MSMS “Lunch and Learn” Policy Webinars**
- Understanding and Preventing Identity Theft in Your Practice – September 3
- Physician Employee Contracting: Understanding and Negotiating Contracts – October 29
- Disability Insurance – November 12
- Physician On-line Ratings and Reviews: Do’s and Don’ts

Please visit website www.msms.org/eo for complete details.

**Diagnosis and Treatment of Physician Burn Out and Sustainability**
- Date: Wednesday, September 24, 2014
- Time: 9:00 a.m. to 3:15 p.m.
- Location: The Management Education Center, Troy
- Contact: Caryl Markzon, (517) 336-7555 or cmarkzon@msms.org
- Intended for: Physicians, executives, administrators, government officials and all other health care professionals

**MSMS Leadership Summit**
- Date: Wednesday, October 1, 2014
- Time: 9:00 a.m. to 3:00 p.m.
- Location: The Lansing Center, Lansing
- Contact: Trish Marsh at 517-336-5734 or tmarsh@msms.org
- Intended for: Physicians, executives, administrators, government officials and all other health care professionals

**Confronting Changes in Payment Reform**
- Date: Wednesday, October 8, 2014
- Time: 9:00 a.m. to 3:15 p.m.
- Location: The Management Education Center, Troy
- Contact: Caryl Markzon, (517) 336-7555 or cmarkzon@msms.org
- Intended for: Physicians, executives, administrators, government officials and all other health care professionals

**The PCMH: Supporting Patients and Population Health**
- Date: Tuesday, October 21, 2014
- Time: 9 a.m. to 3:30 p.m.
- Location: Somerset Inn, Troy
- Contact: Caryl Markzon, (517) 336-7555 or cmarkzon@msms.org
- Note: Continental breakfast and lunch will be provided.
- Intended for: Physicians, administrators, office managers and other health care professionals

**149th Annual Scientific Meeting**
- Date: Wednesday, October 22 through Saturday, October 25, 2014
- Location: Somerset Inn, Troy
- Contact: Marianne Ben Hamza (517) 336-7581 or mbenhamza@msms.org
- Note: Continental breakfast and lunch will be provided.
- Intended for: Physicians and all other health care professionals

**Symposium on Retirement Planning**
- Date: Wednesday, October 22, 2014
- Time: 5:45 p.m. to 8:15 p.m.
- Location: Somerset Inn, Troy
- Contact: Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org
- Note: Dinner will be provided.
- Intended for: Retired physicians, physicians planning for retirement, spouses, and office managers

The Masters Series:
**Medicaid Expansion Under the Affordable Care Act – Michigan’s Response**
- Date: Thursday, October 24, 2014
- Time: 8:30 a.m. to Noon
- Location: Somerset Inn, Troy
- Contact: Caryl Markzon, (517) 336-7555 or cmarkzon@msms.org
- Intended for: Physicians, administrators, and health care executives

New MSMS On-Demand Webinars: Education When You Want It!
- Physician Executive Development Program, featuring The Doctors Company CEO Richard E. Anderson, MD
- CDL-Medical Examiner Course
- Summary of the Affordable Care Act
- HIPAA Security Rule

Please visit website www.msms.org/eo for a complete listing.

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**Symposium for Primary Care Medicine**

Friday & Saturday
November 7-8, 2014
Sheraton Detroit Novi Hotel
Novi, Michigan

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- **Mexican Town**: Detroit. Mostly hard-working Latino practice, 40 patients per day. Hired doctor works with physician owner, could be your part-time or full-time practice, approx. $700,000 gross. Call for pricing of practice and building.

- **Small Livonia Practice**: $30,000.

- **Pediatric Practice**: Detroit, high gross, and thankful patients. Will break in the right person to take over. Reasonable and very flexible terms. MUST BE BOARD CERTIFIED IN PEDIATRICS.

- **Internist Practice**: Farmington. 30+ year practice. Four days per week, 15-20 per day, good insurances… year of transition offered.

- **Belleville-Canton**: High volume primary care practice. Outstanding insurance reviews and compliant patients. Retiring sellers offer flexible transition and terms. Reasonable price on practice and real estate, considering the high gross and room for growth.

Medical Buildings For Sale or Lease

- **Far West Side Detroit**: Multi suite property fully leased, $60,000. Positive cash flow for owner. Very good condition, brick, single story. One suite opened up for your practice. 8,000 sq. ft., private parking. Asking $525,000, or lease at $1 sq. ft./mo.+utilities.

- **Garden City**: Medical practice building, still has equipment, exam tables, EMR. About 1,200 sq. ft., three exams, basement storage, private parking. Asking $129,800 or $900/mo. lease. Seller will finance.

- **Pontiac**: Large professional medical building. Three story, suites 500-5,000 sq. ft. Across from hospital, acres of parking. VERY REASONABLE rates/terms or buy building for $250,000.

For more details contact our practice specialist at Union Realty:

**Joe Zrenchik, Broker**

248-240-2141 (cell)

joezrenchik@yahoo.com

248-919-0037 (office)

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**PHYSICIAN NEEDED** – MD or DO to supervise. Part-time, mainly off-site physician needed for oversight at laser tattoo removal office in Centerline, MI. Primary initial responsibility will be to oversee facility. Approx. 2-4 hour total commitment per month. Flat fee compensation. Call John M., CLS at (586)759-5580.

Physician Grants Announced by BCBSM Foundation

The Blue Cross Blue Shield of Michigan Foundation (Detroit) awarded two research grants to Michigan physicians. Among the grantees are:

- The University of Michigan Medical School, Renuka Tipirneni, MD, ($10,000) to develop and implement a tracking tool that can assess the early impact of health care reform, in Michigan, on primary care access and to monitor changes in access.

- William Beaumont Hospital Research Institute, Michael Rontal, MD, ($9,940) to demonstrate how changes to an external surgical approach to the vocal fold area, guided by endoscopic visualization, may allow for a much smaller amount of Gore-Tex to be placed with better precision by positioning this material exactly to the true vocal fold.

For more information about the BCBSM Foundation

Please contact: Nora Maloy, DrPH, 313.225.8205, nmaloy@bcbsm.com
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CONTINUING MEDICAL EDUCATION SEMINAR
OB/GYN Perspectives & Updates

Wednesday, September 10, 2014 7:30 a.m. – 4:00 p.m.

COURSE DIRECTOR
Michael Prysak, PhD, MD
Department of Obstetrics and Gynecology, St. John Hospital and Medical Center, Detroit, MI

SYMPOSIUM

Prozac Baby: Treating the Mother, Protecting the Unborn
Gideon Koren, MD, FRCPC, FACMT
Director, The Motherisk Program, The Hospital for Sick Children; Professor of Pediatrics, Pharmacology, Pharmacy and Medical Genetics, The University of Toronto; Professor of Medicine, Pediatrics and Physiology/Pharmacology and the Ivey Chair in Molecular Toxicology, The University of Western Ontario, Canada

The Epidemic of Physician Dissatisfaction/Burnout
Louis Weinstein, MD
Department of OB/GYN, Maternal-Fetal Medicine, Thomas Jefferson University, Philadelphia, PA

Detecting In Utero Exposure to Drugs of Abuse and Alcohol
Gideon Koren, MD, FRCPC, FACMT

The History of Physician Compliance with Female Atrocities, Genocide and the Holocaust
Louis Weinstein, MD

Female Sexual Dysfunctions and Treatments: Interventions You Can Make
James A. Simon, MD, CCD, NCMP, IF, FACOG
Clinical Professor, George Washington University, Washington DC

Vaginitis Update
Jack D. Sobel, MD
Chairman, Department of Internal Medicine, Distinguished Professor of Medicine, Wayne State University School of Medicine, Detroit, MI

WHI: Ten Years After: Safely Fitting Hormone Therapy Into My Practice
James A. Simon, MD, CCD, NCMP, IF, FACOG

ACCREDITATION
St. John Hospital and Medical Center is accredited by the Michigan State Medical Society to provide continuing medical education for physicians. St. John Hospital designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This symposium will be held at the Grosse Pointe War Memorial, 32 Lakeshore Dr., Grosse Pointe Farms, MI 48236

Continuing Medical Education: St. John Hospital & Medical Center Upcoming Programs 2014-15

- October 22, 2014 – Family Medicine Seminar
- December 3, 2014 – Cardiology Update
- March 4, 2015 – Surgery Seminar

For more information contact:
313-343-3877 as these may be subject to change.

These dramatic changes in our system are presenting physicians with a ripe opportunity to mold these changes for a better system for patients. “It’s a wonderful sign that physicians are expanding from clinical care to learning what it takes to be a good leader,” said Maureen Bisogagno, President and CEO of the Institute for Health Care Improvement. “When you can marry the clinical background and the leadership skills, you have an opportunity to lead in a very different and distinct way. When you get someone who knows what quality looks like and pair it with a curiosity about new ways to think about leading, you produce leaders who are providing dramatic innovations in the field.”

Health care is becoming more complex and we are going to need leaders who understand more than balance sheets and buildings, but also a deep understanding of the clinical arena and the entire spectrum of patient care.

As this trend continues, the 2014 election cycle has 26 physician candidates for both the U.S. House of Representatives and Senate. One of those 20 is anesthesiology colleague, Andy Harris, MD, (R-Maryland), who is doing a terrific job in representing the profession and the patients we serve. It is truly refreshing to know that there is a growing voice in Congress for what you believe is best for the profession and our patients.

Leadership is inherent in the profession of medicine. It’s what professionals do. We profess. We speak out for the greater good. Use your standing. Use your voice. Speak out for what you believe is best for the profession and our patients. I’m the first to acknowledge that it’s not easy. It takes time and energy. But it is essential for physicians to speak up, take part, and break out of our shells to create the health care world we want for ourselves and our patients.

Together, we all will be leaders who continually work to build a patient-focused system that is based on quality, safety, outcomes, and value. Thank you for your leadership.

Doctor Grant, a Royal Oak anesthesiologist, is President of the Michigan State Medical Society.
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- Appeals of RAC, Medicare, Medicaid & Other Third Party Payor Claim Denials & Overpayment Demands
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