Are You Satisfied?

What Drives Physician Professional Satisfaction in a Time of Dwindling Face-Time with Patients?

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COVER STORY


A new RAND study shows that time with patients, collegiality, and modern delivery obstacles like EHRs all impact physician professional satisfaction, and some practices are adapting to a changing health care environment to help physicians find joy in their profession.

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Liability for Intentional Illegal Disclosures of Medical Record Information by an Employee

By Daniel J. Schulte, JD

QUESTION:
I recently discovered that one of my employees disclosed a patient’s medical record information to a common friend while gossiping about the patient. I have followed my attorney’s advice and implemented policies and procedures to comply with the HIPAA Privacy Rule and Security Rule. They obviously did not prevent this from happening. Fortunately, another employee followed our policy and reported the disclosure to me when it was discovered by her. What liability does my practice face as a result of this? How should I sanction this employee?

ANSWER:
As a result of this illegal disclosure your practice may incur liability for fines, penalties and other sanctions imposed by regulatory authorities pursuant to various federal law (HIPAA) and damages to the patient pursuant to state law.

As you must know, HIPAA makes medical record disclosures without patient authorization for reasons other than treatment, payment or health care operations illegal. Unfortunately, even the best compliance with the HIPAA Privacy Rule and Security Rule cannot eliminate the possibility that an employee will intentionally make an illegal disclosure. Assuming you have properly complied with the HIPAA Privacy Rule and Security Rule by enacting and following the required policies and procedures, the fact that the disclosure was the result of an employee’s intentional illegal act should result in a low risk of fines, penalties and other sanctions being imposed for this HIPAA violation.

A recent case (Doe v. Guthrie Clinic Ltd.) decided by a federal appellate court is instructive on the likelihood of your practice being liable for damages under state law. In Doe, the patient (“John Doe”) was being treated for a sexually transmitted disease (“STD”) at the Guthrie Clinic. A nurse employed by the clinic recognized the patient as the boyfriend of her sister-in-law. The nurse accessed Doe’s medical records and learned he was being treated for the STD and sent text messages to her sister-in-law informing her of Doe’s condition. The text messages were immediately forwarded to Doe, who complained to his physician. The clinic fired the nurse.

Unsatisfied, Doe sued the clinic. His suit alleged breaches of various state law duties (the opinion does not mention violations of HIPAA or that HIPAA complaints were made to regulatory authorities – presumably this is because the clinic had complied and had proper policies and procedures in place that were violated by the nurse). Ultimately, the court dismissed all of Doe’s claims against the clinic concluding that it could not be held liable for the intentional illegal acts of its employee. Doe was decided under New York law. However, I believe the result would likely be the same if it were decided under Michigan law. Assuming you have complied with HIPAA by establishing the required policies and procedures, trained your employees as to what they require and have enforced them and expected that they consistently follow them the risk of your patient recovering damages as a result of an illegal intentional employee disclosure should be low.

You will note that the employee in the Doe case was terminated. It is hard to know what impact this fact had on the courts when deciding whether or to dismiss Doe’s claims. It is reasonable to assume that retaining this employee following the revelation of what she had done would not have improved the clinic’s position in litigation.

More important than assessing your position in litigation is ensuring that you employ only trustworthy employees that will follow your policies and procedures.

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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Taking Care of Patients Begins By Taking Care of Yourself

By Sandra Carter, MBA, PhD

Traditionally, physicians have been at the pinnacle of the doctor-patient relationship, positioned as experts. With the emergence of patient-centered care structures, the patient more recently has been the primary focus in the doctor-patient dyad. The RAND study reminds us of an essential truth: the doctor-patient relationship is fundamentally interdependent: what influences one person positively or negatively also influences the other person.

According to the study, a key driver of job satisfaction for physicians is having the ability to provide high-quality patient care, and when physicians’ efforts are thwarted by numerous environmental obstacles, this becomes a source of stress among physicians.

Primary findings suggest that by monitoring physician dissatisfaction, deeper quality issues in health care systems can be identified early on. Monitoring physician dissatisfaction has implications as early warning signs for burnout symptoms as well. Research shows prolonged physician dissatisfaction can develop into burnout, resulting in serious consequences for physicians, patients and health care systems. Studies indicate patients treated by burned-out physicians are less satisfied and slower to recover from their illness.

In a recent study, researchers at the Mayo Clinic surveyed a national population of 7,288 physicians on their quality of life and job satisfaction. The results showed 46 percent of respondents reported at least one burnout symptom. A standard evaluation tool called the Maslach Burnout Inventory (MBI) was used to assess physicians’ well-being. The three classic signs of burnout as measured by the inventory are emotional exhaustion, defined as feelings of being overextended or exhausted; depersonalization, feeling disconnected and impersonal towards others; and diminished personal accomplishment, which are feelings about lack of success in one’s work. Women tend to experience emotional exhaustion first, feeling like they’re drained and running out of energy. Men often experience depersonalization and feelings of cynicism initially, and if this evolves, staff members and patients are treated like objects.

The primary causes of burnout also correlate with factors that physicians see as barriers to delivering high quality patient care. For example, excessive work load, lack of control and autonomy, unfairness, incongruence of values, isolation, inefficiencies due to administrative burdens, and uncertainty about the future are just a few of the factors identified.

Burnout is a dynamic process and is the result of chronic negative stress conditions that eventually rob people of the joy and meaning their work once offered. Burnout is more prevalent in physicians than other US workers, and when left unresolved or unattended, can result in a number of negative behaviors.

The factors contributing to physician burnout are varied and complex, and relate to cultural expectations, physicians’ personalities, and organizational structures. Traditionally, our culture has viewed physicians as liberators of disease, and as heroes who will save us as we deal with illness and loss. Physician personality characteristics can predispose them to stress. Typically, physicians have tried to meet patient expectations, stepping into their role as highly motivated professionals with an intense investment in their work. Physicians tend to be conscientious, often have an exaggerated sense of responsibility, and perfectionistic tendencies that make them reluctant to delegate.

In addition, due to training and conditioning, many physicians have diminished self-awareness related to their emotional and physical needs, or practice denial to maintain a strong reserve to avoid personal vulnerability.

At the organizational level, problems exist within health care delivery systems. As our organizations undergo transformational change attempting to deal with fragmentation and ambiguity at record levels, administrators and physicians do not always find themselves aligned with each other. Conflicted purposes and low trust always find themselves aligned with each other. Conflicted purposes and low trust can predispose them to stress. Typically, physicians have tried to meet patient expectations, stepping into their role as highly motivated professionals with an intense investment in their work. Physicians tend to be conscientious, often have an exaggerated sense of responsibility, and perfectionistic tendencies that make them reluctant to delegate.

In addition, due to training and conditioning, many physicians have diminished self-awareness related to their emotional and physical needs, or practice denial to maintain a strong reserve to avoid personal vulnerability.

At the organizational level, problems exist within health care delivery systems. As our organizations undergo transformational change attempting to deal with fragmentation and ambiguity at record levels, administrators and physicians do not always find themselves aligned with each other. Conflicted purposes and low trust are all too common, making it challenging or impossible to collaborate and achieve synergy towards positive patient outcomes with physician satisfaction and well-being.

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self-awareness, and learning various skills, such as mindfulness/meditation, training in interpersonal communication (emotional intelligence), and reconnecting with meaning in their work, promoting separation between hospital and home life and better self-care.

In addition, one of the most significant factors in resistance to stress is the strength of the physician’s support system. Peer support groups and reflective coaching have proven useful to physicians by decreasing isolation, and establishing a sense of community. The RAND study indicated physicians felt a loss of interpersonal connection with partners and colleagues when meetings were discontinued, as a result of groups becoming part of larger organizational systems. Ironically, conversations and connections become more essential once smaller physician groups merge with larger organizations. Seldom do physicians speak about their personal and professional lives, and it can be very liberating to recognize that you are not alone!

These types of changes are transformative and evolve over time in a series of steps that progressively change how one values and cares for themselves. This is a deep change that creates self-awareness and expands narrow thought patterns at the level of identity. Management guru Peter Drucker said we have a natural resistance to this type of change (and defensive structures fortified by strong emotions). According to Drucker, we possess an “emotional glass ceiling” that we are psychologically programmed to avoid breaking through. Drucker states that when we engage in powerful conversations, we can move beyond our resistance. Drucker also writes that anyone engaging this level of depth must become acquainted with courage.

If there ever was a time for stepping into courage, the time is now. The survey concludes that burnout among US physicians is an epidemic rising at an alarming rate, and is a systemic problem threatening the very foundation of the US healthcare system. It is a problem that needs to be addressed at many levels including policy makers, health care organizations, patients, and physicians.

When we heal ourselves, we offer our services from a higher wisdom and an open heart. We foster healing relationships from an inner strength, engagement, self-awareness, and appreciation for the whole person. When physicians are connected to their callings, they know the locus of healing is neither in the patient, nor the healer, but in the space created by the connection (the relationship), between the two, where both parities discover joy and purpose beyond the illness. Successful healthcare transformation depends first and foremost upon successful physician transformation – which depends upon physicians maintaining well-being, resilience and health. If you are experiencing burnout or recognize burnout symptoms, take steps to get support.

The author is a member of the International Coaching Federation and is a Professional Certified Coach (PCC). Additionally, she is certified as a Physician Development Coach.

www.drleadershipcoaching.com

Continued from page 6
Differences in the early symptoms and signs of an impending heart attack in women may make diagnosis more difficult compared to men.

In a study of closed medical malpractice claims involving undiagnosed heart disease in women, The Doctors Company found that in 61 percent of claims the patient died when her heart condition was not correctly diagnosed and 33 percent had heart muscle damage from myocardial infarction.

In the following case, failure to diagnose acute myocardial infarction resulted in death.

A 47-year-old obese woman presented to her primary care physician complaining of a burning sensation in her chest after eating. The patient reported a similar episode the prior day after eating lunch, as well as increased heartburn over the last few weeks.

A review of the medical record reflected elevated blood pressures over the past six months and an elevated cholesterol level of 237 (mg/dl). On the day of the exam, her blood pressure was 160/90. She smoked, drank alcohol socially, and was unaware of a family history of coronary artery disease. A heart exam revealed normal rate and rhythm. The physician noted that the patient appeared diaphoretic; however, she wasn’t in acute distress and was pain-free throughout the examination. An ECG revealed a left bundle branch block. Prior ECGs were not available for comparison. Suspecting reflux esophagitis (heartburn), the PCP advised the patient to take an antacid and to return if the symptoms continued.

Two days later, the patient called her PCP’s office stating that her chest burning sensation continued. The nurse advised her to continue taking the antacid and scheduled an office appointment for the following day. The nurse advised the patient to go to the ED if she developed chest pain.

That night, the woman awoke with chest pain, nausea, and vomiting. She was taken to the ED for emergent coronary angiography, but died shortly after arrival.

To avoid such risks:

- Rule out myocardial infarction before arriving at a GI-related diagnosis such as gastric reflux as the cause of chest pain or discomfort.
- Consider cardiac risk factors such as obesity, smoking, hypertension, and hyperlipidemia.
- Offer patients same-day appointments when they complain of continued symptoms for which they were recently seen. If this is not possible, send them to the ED and document this in the medical record.
- Develop a written chest pain protocol.

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 More Information

For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.
Pinckney family physician Barbara L. Saul, DO, FAAFP, remembers a time when a typical workday meant eight hours at the office caring for patients and time after work spent with family, personal outings and visits with the grandchildren. Free time included participating in community outreach programs, leading medical research initiatives and teaching medical students.

But Doctor Saul’s life changed drastically with the implementation of electronic health records. Now, she spends three hours after work entering patient data, reviewing labs and documenting, she said. The doctor frequently misses family activities and has had to give up her favorite pastimes.

“It has significantly impacted my life as a physician in ways I couldn’t imagine,” Doctor Saul said of EHRs. “Those were wonderful things in my life that provided me joy. All those things had to go by the wayside when the electronic health records came because I didn’t have time for them.”

The same frustrations are playing out in doctors’ offices across the country. EHR systems – and the burdens they bring – are a primary driver of physician dissatisfaction in the US, according to a RAND Corporation study sponsored by the American Medical Association and released in October. The report, “Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy,” analyzed perspectives from 30 physician practices in six states about satisfaction. Doctors in Colorado, Massachusetts, North Carolina, Texas, Washington and Wisconsin were surveyed and later interviewed by researchers.

EHRs were a top contributor to physician dissatisfaction, largely due to cumbersome interfaces and interference with face-to-face patient discussions, the survey found. Other key discontentment factors included excessive productivity quotas and time limitations with patients. Doctors also cited the cumulative burden of new rules and regulations as being overwhelming and draining time and resources away from patient care.
The survey results are consistent with the concerns of Michigan physicians, said John E. Billi, MD, professor of internal medicine and medical education and associate vice president for medical affairs at the University of Michigan in Ann Arbor. He served on an AMA advisory panel that provided input on the RAND report.

“The findings are completely typical of what we find when talking to doctors in Michigan,” Doctor Billi said. “There are many doctors in Michigan who have not yet implemented electronic medical records. Those physicians are worried about the issues talked about in the RAND study,... I think the physicians in Michigan share all of the factors that were described in this study.”

Physician dissatisfaction has a more widespread effect than some might think. Medical experts say unhappy doctors can impact quality of care, workforce numbers and the patient experience. But what might improve the satisfaction climate among physicians and lead to more efficient care? Doctors and analysts are working hard to answer those questions and find strategies to increase physician contentment. However, some believe the growing regulatory landscape will worsen satisfaction among doctors before it gets better.

**The Good, Bad and Ugly of EHRs**

Doctor Saul stresses that electronic health records have many benefits, such as advancing research and helping to track patient information.

“It truly is a double-edged sword,” she said. “The electronic health record does some wonderful things. We’re not turning around. We need to go in this direction, but we’re taking baby steps.”

Her sentiments are reflected in the RAND survey. Physicians approved of EHRs in concept and appreciated having better ability to remotely access patient information. However, a majority of physicians cited negative aspects of current EHRs, such as poor usability, time-consuming data entry, inefficient and less fulfilling work content, inability to exchange health information, and degradation of clinical documentation.

Displeasure with EHRs was one of the more surprising results of the study, said F. Jay Crosson, MD, the AMA's group vice president for Professional Satisfaction, Care Delivery and Payment and an architect of the study. In fact, researchers altered the interview questions to delve more deeply into EHR concerns after initial study results revealed such widespread discord, he said.

“We didn't really expect to see the level of concern about the usability of electronic health records,” he said. “Not that it's a mystery that electronic health record use has created efficiency problems.”

Dearborn trauma surgeon Kurt Kralovich, MD, FACS, concurs with the findings. He notes that, disappointingly, EHRs have not enabled better communication between practices and health care centers.

“Because [EHRs are] essentially an unfunded mandate, most practices shop around and sign with a low-cost provider,” said Doctor Kralovich, an Oakwood Hospital Medical Center surgeon and president-elect of the American College of Surgeons, Michigan Chapter. “Every office, clinic, or hospital is able to sign on with a different software provider. People cannot communicate with each other via the computer. Physicians share data through letters, fax, email in a timely
fashion and therefore the EHR becomes a duplicate effort with little value added.”

Physicians and other providers recognize that it will ultimately be useful to have EHR data, and that the systems can improve patient care, care coordination, and outcomes, adds Kara Zivin, PhD, associate professor of psychiatry at the University of Michigan Medical School and an associate professor of health management and policy at University of Michigan School of Public Health. However, the real costs of time and patient-provider interactions have not been fully addressed, she said.

“The general assessment from our health system seems to be that transitions in use of EHRs have been much more time consuming, burdensome, and have taken longer than initially expected,” said Doctor Zivin, who is also a research scientist for the Center for Clinical Management Research at VA Ann Arbor Healthcare System.

Meaningful Use Rules Cited as Burdensome, Time Waster
Physicians surveyed also cited “meaningful use,” as having predominantly negative effects on professional satisfaction.

Doctors expressed frustration with the time, documentation, and lack of flexibility meaningful use rules imposed. They lamented also on their incongruity with clinical practice and their contributions to the current state of EHR technology.

Owosso family physician Fred J. Van Alstine, MD, knows first-hand the burden that meaningful use can bring a practice. His solo practice was recently chosen for a meaningful use audit, which meant weeks of sifting through mounds of paperwork and losing staff productivity. Doctor Alstine’s wife, who doubles as his office manager, spent hours completing the audit’s requirements, he said.

“It was a nightmare,” said Doctor Alstine, who is president for the Michigan Academy of Family Physicians. “It was such tremendous stress. [My wife] actually cried.”

Regulations and requirements continue to grow for physicians from both government and private insurers, adds Doctor Kralovich. The increasing regulations are distracting and weigh heavily on time with patients, he said.

“It is absolutely true that a minority of my time is spent with patients,” he said. “The majority of my time is spent with paperwork or computer screens. No physician went to medical school to do paperwork or fill out online forms. It is the human interaction that will make one feel fulfilled. Physician satisfaction will vary directly with the percentage of patient care they perform and inversely with the amount of documentation required.”

Adding to the complexity of the current regulatory landscape is the fact that patients are becoming older and their needs more diverse, Doctor Crosson said.

“It’s not uncommon to have multiple patients in their 80s and 90s with five or six medical conditions, as well as the fact that there are many more things every year that we can do for patients,” he said. “But in many settings, that has created additional tasks; more complex documentation from the staff to the doctor.”

Visits with older patients also may take longer because of hearing, visual and other physical or cognitive impairments, notes Helen C. Kales, MD, director of the Section of Geriatric Psychiatry and the Program for Positive Aging at the University of Michigan.

“In addition, there are often caregivers involved, which is on one hand incredibly helpful, but on the other hand may increase the time needed in a particular visit,” she said. “However, I would strongly state that older patients are not going to go away. With the aging of the baby boomers, they are going to become a large part of many practices. We need to find ways to better equip physicians on the front lines with the training, skills and systems to better allow them to manage the older patient.”

Fair Treatment Vital Factor in Happiness
Physicians’ perceptions of collegiality, fairness and respect are also key determinants of professional satisfaction, the study found.

Physicians reported four main areas in which these constructs operated: relationships with colleagues in the practice, relationships with providers outside practice, relationships with patients, and relationships with payers.

“The study showed that physicians are not motivated primarily by the financial aspects of the profession,” said Christine Sinsky, MD, FACP, an internist for Medical Associates Clinic & Health Plans in Dubuque, IA. She is a consultant to the AMA’s strategic initiative of improving physician career satisfaction and practice sustainability and helped provide input for the RAND report.

“It is the content of the work – the knowledge that we are working on our patients’ behalf and not simply overwhelmed with administrative tasks, data entry and clerical work – that motivates physicians.”

She adds that one of the biggest pain points for physicians and other health professionals is a lack of influence over the environment in which they practice.

“One of the biggest barriers to achieving the Triple Aim for the health care system is that the people closest to the patient have limited authority over the details of their work,” she said.

The Triple Aim refers to a framework developed by the Institute for Healthcare Improvement that describes an approach for optimizing health system performance. The approach centers on designs that simultaneously pursue three dimensions: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

The AMA is currently creating a series of practice engagement activities to help physicians restructure their office practices to provide the highest quality, be more efficient and reclaim the joy of practice. The first of the series is scheduled to be released later this year.

Practices Make Headway in Reclaiming Joy
Despite facing new challenges, physicians today still note many reasons they enjoy their practices and find pleasure in their work. Partnerships with patients, for instance, rate high on physicians’ lists of contentment factors.

“My relationships with my patients and their families truly [are] the most gratifying part of my clinical work,” Doctor Kales said.

“The ability to improve functioning for patients and quality of life for both patients and their families, the privilege of hearing patient’s stories [is satisfying]. I learn a lot from interacting with and treating patients, not only in the clinical experience I gain with each interaction, but also in terms of the life experience that each patient brings to the table.”

Doctor Billi agrees that long-term relationships with patients is key to contentment.

“Every week I feel honored that these people, who have now become like long-time friends, have let me into their lives to
help them with their health care problems, large and small,” he said. “It is because of the patients that I do the management and improvement work that I spend the rest of my time doing.”

Strong patient relationships were noted in the RAND survey as important to physicians’ conceptions of high-quality care. Some physicians in leadership roles said they were able to facilitate these relationships through more individualized care and more contacts with patients.

In addition, an article co-written by Doctor Sinsky details how a number of practices across the country are succeeding in bringing joy back into their work lives.

The report, published in the May/June 2013 Annals of Family Medicine explored areas where physicians are thriving after having found innovative solutions to common challenges. Authors analyzed 23 high-performing primary care practices representing different geographic regions, practice sizes and delivery models.

Researchers' observations suggest that a shift from a “physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction and greater joy in practice.” Success stories included the following:

• At Mayo Clinic Health System – Red Cedar in Menomonie, patients at the Wisconsin health center have their laboratory tests completed before their appointments and are able to discuss results and engage in shared decision making at the time of the visit. The system eliminates an hour or more a day of post-appointment results reporting.

• At North Shore Physicians Group (NSPG) in the Boston area, the medical assistant's role has been transformed. When patients are taken to an examination room, the process has been expanded from three minutes to eight minutes and now includes medication review, agenda setting, form completion and closing care gaps. The role transformation is part of a larger team-care initiative at NSPG that has resulted in a 14 percent increase in primary care physician satisfaction scores.

• At the Cleveland Clinic Strongsville Family Health & Surgery Center in Ohio, medical assistants and registered nurses work with primary care physicians to help expand rooming protocols. Physician extenders return with physicians to record notes while the doctor talks with and examines the patient. After one year in the new model, average daily visits increased, revenue rose and quality metrics, as well as patient, staff, and physician satisfaction scores, improved.

“The MAs and nurses are more fully engaged in patient care than they have ever been and they enjoy their work,” said Strongsville Family Health Center family physician Kevin Hopkins, MD, in the Annals report. “They have increased knowledge about medical care in general and about their individual patients in particular. I am far more satisfied. I leave work an hour earlier every day and have a very fulfilling relationship with my team.”

The Annals study results show that to increase physician joy and decrease burnout, there must be a socio-technical-policy environment that supports doctors and their teams in their service of patients,” Doctor Sinsky said.
"This means a team-based model of care where tasks and outcomes are not just the responsibility of the physician but are shared with the team," she said. "Team-based care means relying on a well-trained team. Physicians and their care teams derive their greatest satisfaction from caring for patients. We need to keep working so that the external environment empowers them in this mission."

**Contentment Influences Quality Health Care**

The ripple effect of physician satisfaction impacts far more than only doctors themselves, said Mark W. Friedberg, MD, the study's lead author and a natural scientist at RAND, a nonprofit research center.

"If you have physicians who are satisfied, they are going to provide better care for patients," he said. "If you have physicians who are burned out and at the end of their rope, they may not be able to provide as compassionate care. Physicians' perception of the quality of care they deliver is actually a major component of quality of care."

Early retirement is another unfortunate effect of physician dissatisfaction, said Doctor Saul. She has seen a number of colleagues retire early because they were unhappy with quality of care and the time it takes to document.

Doctor Saul can empathize.

"I went to medical school because I wanted to interact with people and help them have a better life," she said. "At the end of my career, what I'm spending most of my time doing is interacting with a computer."

The RAND report sought to examine the downstream effects of physician professional dissatisfaction on patient access to care, physician workforce, physician retention and health care costs.

While researchers found no published studies examining direct relationships between physician professional satisfaction and patient access to care, several studies identified a significant relationship between decreased physician satisfaction and greater workforce attrition. A study in the 2000 *Journal of General Medicine* that utilized data from the Physician Worklife Study examined reported intent to leave a practice within two years. The study found dissatisfaction was strongly associated with reported intent to leave, although no data were available to determine whether physician job turnover actually occurred.

Physicians leaving medicine or retiring early because of discontentment would come at a time when more – not fewer – physicians are needed in the US, Doctor Crosson said. According to the Association of American Medical Colleges, there will be 45,000 too few primary care physicians – and a shortage of 46,000 surgeons and medical specialists – in the next decade.

"Through the Affordable Care Act, more people are coming into the health care system. It is not surprising that the perceived value-added and non-value-added steps in every process is the beginning of the lean approach."

The University of Michigan Health System has been employing lean strategies for nearly 10 years, having created the Michigan Quality System, led by Doctor Billi.

In addition, doctors should work to develop a relationship-centered culture – in which the same people work together in small teams every day and continuity between clinicians and providers is a priority, Doctor Sinsky said. Planning forward rather than reacting backward is also key.

"By spending less time looking backward and playing catch-up, practice teams can spend more time looking forward and being proactive," she said. "Retrospective care feels burdensome; prospective care feels valuable."

It all comes down to contributing to patient betterment and accomplishing the true purpose of going into medicine, adds Doctor Kralovich. "I think all physicians live more satisfied lives when they have good relationships with patients and have the ability to give high quality care," he said. "They have dedicated their lives to that process. It is not surprising that the perceived quality of life is impacted by occupational factors. The training is too long and the sacrifices are too great for people to stay in medicine if they are not in it for the purposes of providing high-quality care to patients."

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**Bettering the Satisfaction Landscape**

For Doctor Van Alstine, there came a point when he considered quitting his profession, he said. The transition to EHRs was exhausting and expensive, his practice was constantly running behind, and his patient relationships were suffering.

Three years ago, however, he made the decision to hire a medical assistant to act as a scribe. The move has drastically improved his practice and work life, he said. The assistant enters data while Doctor Van Alstine treats patients in the exam room.

“She’s great,” he said. “We’re back on time and able to see a reasonable volume. I’m able to focus on” the patient again.

The use of medical assistants and other health professionals could be one way to lessen physician workload and more efficiently manage time, say medical experts.

“We need to use allied health professionals who can help us enter data and utilize the electronic health record,” Doctor Saul said. “It can’t all be left to the physician. [Physicians should ensure] receptionists, nurses and medical assistants all have significant training in how to use the electronic health record.”

The RAND report concludes that collaboration is essential among EHR vendors, physician professional associations, hospitals and other provider groups to improve the usability and interoperability of EHR. In addition, federal EHR certification criteria should include, in some form, the notion that a minimum level of system usability will be necessary to have desired effects on the quality and efficiency of patient care, the report said.

In the meantime, physicians can take steps now to improve their happiness and professional wellbeing. Doctor Sinsky recommends physicians re-engineer their workflows to eliminate wasted effort and reclaim an hour or more physician time per day.

“There is a great deal of improvement physicians and teams could do around prescription management, pre-visit planning and lab/test results reporting that could free up time and resources,” she said.

Doctor Billi stresses that practices should consider using better program-solving methods, such as the “lean” model. Lean management principles are based on driving out waste so that all work adds value and serves physician and patient needs. Identifying value-added and non-value-added steps in every process is the beginning of the lean approach.

The **Contentment Influences Quality Health Care**

The author is an Indiana-based medical writer.
Training Now Required on OSHA's Revised Hazard Communication Standard

In March 2012, the Occupational Safety and Health Administration (OSHA) issued a final rule revising its Hazard Communication Standard (HCS) to conform to the United Nations globally harmonized system of classification and labeling of chemicals. The revised HCS modifies the existing standard adopted in 1994. Those affected by the revised HCS (e.g., chemical manufacturers, importers, distributors, users, etc.) are subject to several compliance deadlines phasing in the requirements of the revised HCS beginning on December 1, 2013, and continuing until June 1, 2016. The goal of the revised HCS is to improve the quality of warnings regarding hazardous chemicals in the workplace. This is done by revising/adding the following to chemical labeling:

1. PICTOGRAMS. Symbols are surrounded by a red diamond shaped border. The symbols convey specific information regarding the hazards associated with a chemical (e.g., health hazard, flammable, corrosive, explosive, etc.).

2. SIGNAL WORDS. Certain signal words indicate the relative level of severity of the hazard the chemical presents (e.g., “Danger” is used for more severe hazards; “Warning” is used for less severe hazards).

3. HAZARD STATEMENTS. These statements describe the nature of the hazard of a chemical, including the degree of the hazard where appropriate.

4. PRECAUTIONARY STATEMENTS. These statements convey recommended measures to be taken to minimize or prevent adverse effects resulting from exposure, improper storage or handling of a chemical.

OSHA has required the maintaining of a safety data sheet (SDS) when using, manufacturing, and distributing hazardous chemicals. This requirement under the revised HCS remains present; however, the SDS form is in a revised format.

A physician’s office potentially contains several types of hazardous chemicals. Beginning December 1, 2013, physician offices are required to conduct training of employees on the new labeling and revised SDS form.

The Michigan Department of Licensing and Regulatory Affairs’ (LARA) website makes available narrated PowerPoint modules and a recorded webinar that can be used to conduct this training. Visit the LARA website at http://1.usa.gov/19Ahglk.

Also, included in these materials is a standardized form that can be used to document that the employee training has been conducted. This form should be completed and retained with the SDS forms maintained by the office.
Keeping Michigan Healthy: That’s the Plan

Physicians Play Critical Role in the Medicaid Expansion

By Stacy Sellek

expansion [ik-span-shuh - n] n. – the increase in the dimensions of a body or substance when subjected to an increase in temperature, internal pressure, etc.

Looking back at the process of passing the Medicaid expansion legislation (a.k.a., the “Healthy Michigan Plan”), it was unquestionably subjected to great pressure and plenty of heat.

And Stephen Fitton, Director of the Medical Services Administration that runs the state’s Medicaid program, was charged with the Herculean task of making the case for expansion to legislators.

“There was popular notion [in Lansing] that, ‘Medicaid is broken and why are we putting more people in it?!’,“ recalls Fitton. “My main job was explaining to legislators that the system wasn’t broken, that it was working.”

Fitton, who has held his current post since 2009, accomplished that by using one of the Snyder administration’s watchwords – wait for it – metrics.

“With our data, we can show that children are getting the tests they need and pregnant women are getting the prenatal care they need, for example,” Fitton explained. “One big area of concern over the years has been lead testing in kids. Since we have addressed that issue in Michigan, we have considerably...
Healthy Michigan Plan Basics

- Expands coverage to adults less than 65 years of age with annual income level up to 133 percent of poverty (approx. $15,521 for an individual and $31,720 for family of four)
- Requires cost sharing up to 5 percent of income for those between 100–133 percent of poverty beginning six months after enrollment
- Healthy behaviors can reduce cost sharing, minimum contribution is 2 percent
- Requires cost-sharing accounts

For example: An individual with an annual income of $12,000 per year will be obligated to contribute 2 percent to his or her MI Health Account, or $240, during the course of a year. This results in a beneficiary contribution of $20 per month into the beneficiary’s account.

lowered the levels and played a significant role in improving the health of Michigan’s children.”

Once the legislative hurdles had been overcome, Fitton and his team at the Medical Services Administration (part of the Michigan Department of Community Health) set to work on making sure there was a viable system in place by April 1, 2014, the scheduled rollout date.

“We’ve started on the inside and are working our way outward. It’s been a matter of breaking it down and parceling out the pieces,” says Fitton, about launching the new program. “We have partnerships with other state departments: the Department of Technology, Management and Budget has been significantly involved in the IT components; and the Department of Human Services has worked on the eligibility process.”

He credits his “great staff” with “stress-testing” all the components to ensure their readiness by the April 1 launch.

‘Pivotal’ Partnerships

Because the Healthy Michigan Plan will require physicians to complete and file Health Risk Appraisals with the state for these new patients – again, metrics – there is a greater burden placed on their already-precious little time with patients.

That is not lost on Fitton, who acknowledges that although this requirement adds to the physician’s overall workload, the state attempted to offset that by lifting another burden from medical practices: collecting co-pays from these patients. That responsibility lies with the qualified health plans that have contracts with the state.

“The physician community is pivotal in this process because they are eyeball-to-eyeball with patients and truly understand their health challenges,” he says. “It’s important that these patients have access to care. We hope that more physicians, particularly primary care physicians who are most impacted by this, will be open to seeing more Medicaid beneficiaries.”

What Physicians Need to Know

- Currently enrolled Medicaid providers are automatically providers for the Healthy Michigan Plan
- Adult Benefit Waiver beneficiaries were transitioned into the Healthy Michigan Plan effective 4/1/14
- Check CHAMPS to verify Healthy Michigan Plan benefit coverage
- See Bulletin MSA 14-11 for Healthy Michigan Plan guidance to providers
- Traditionally eligible = collect co-pays; Healthy Michigan Plan Managed Care = do not collect co-pays
- Complete health risk assessments for beneficiaries with Healthy Michigan Plan coverage
- Direct patients to the following three options for applying:
  - Online at www.michigan.gov/mibridges
  - By phone at 855-789-5610
  - At their local Department of Human Services office (locations: www.michigan.gov/dhs)

For more information, visit www.msms.org/healthymichiganplan.
New MSMS Legal Alert

MSMS's most recent legal alert addresses questions from practices and physician organizations related to HIPAA and the sharing of patient data utilizing a health information exchange (HIE) organization.

Michael A. Genord, MD, MBA, an Oakland County obstetrician/gynecologist, agrees. As Vice President & Chief Medical Officer at HealthPlus of Michigan, a not-for-profit HMO serving 61,000 Medicaid beneficiaries in Genesee, Saginaw, Lapeer, Shiawassee, Tuscola and Bay Counties, he sees both challenges and opportunities for physicians with the advent of the Healthy Michigan Plan.

“The state rules and regulations, no doubt, will bring challenges for physicians and their staff, but there is also a great opportunity to deliver care to people who weren’t covered before,” says Doctor Genord, who serves on the MSMS Board of Directors. “We also have an opportunity to build local partnerships to make our communities healthier, which fits in with the valued-based proposition of health care now.”

So how does HealthPlus plan to assist its 900 primary care physicians and 1,800 specialists with the transition?

“We have a unique health plan and a rich history of working with physicians in a collaborative way,” says Doctor Genord. “We are taking a multi-prong approach to this transition. By being proactive in getting out to our physicians’ offices to discuss the process and leveraging relationships with larger community agencies such as county health plans, we hope to make it go as smoothly as possible.”

The Economics of Behavior

After overcoming legislative obstacles and working to bring physicians into the fold, Fitton and his team have another major task: getting buy-in from these patients who are being asked to take more personal responsibility for their health.

In 2013, there were only 10 other states that ranked higher in obesity rates and only 18 others that ranked worse in overall health than Michigan, according to data released this year by the United Health Foundation. On top of that, Michiganders are big smokers and consumers of alcohol.

With those statistics in mind, the Healthy Michigan Plan includes measures to incentivize the targeted populations – mostly low-income, non-disabled adults – to adopt healthier lifestyles and make those numbers go down.

How does Fitton expect to convince private citizens to follow the state's requirements of taking preventive steps to live healthier?

Two words: behavioral economics. Fitton was introduced to a behavioral economist as part of the Medicaid Leadership Institute that he and a handful of other state Medicaid directors were selected to participate in last year. He was able to secure a grant to bring an expert to Michigan to advise and help design that part of the Healthy Michigan Plan.

“Most of the standard economics is: if it’s financially advantageous for a person, that’s what they’re going to do. And the behavioral economics is: it’s a little more complicated than that,” he explains. “People are not totally rational, and money isn’t going to drive every decision. So I think [behavioral economics] adds a nuance that’s helpful.”

Doctor Genord adds, “The bottom line is that instead of these patients being forced to seek care in emergency rooms, we have the opportunity to bring them into the fold and work with our provider community to get reimbursement for the care they deliver and get these patients in the most appropriate place to have care delivered.”

Contact Dara Barrera at MSMS djbarrer@msms.org or (517) 336-5770. Also, visit www.msms.org/hit.

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Contact Dara Barrera at MSMS djbarrer@msms.org or (517) 336-5770. Also, visit www.msms.org/hit.

The author is senior manager of communications at MSMS.
Have you found yourself wishing you had more time to take care of your financial matters? The demands of career, family, education and other obligations rob us from investing into a critical area – ourselves. Reviewing investments, taxes, retirement and estate plans sounds like a good idea, but every step takes time.

Although physicians are highly skilled and have various advisors, many are unsure of where they stand in relation to their financial goals. They lead busy lives and end up ignoring the advice of John Wooden (famed basketball coach), who said, “Never mistake activity for achievement.”

**Ask the Right Questions**

So what is the best way to get your financial affairs in order and find out where you stand? Simply create a financial plan. Start this process by pausing in your busy schedule to ask some of the following questions:

- What are my most important financial goals?
- What risks could prevent me from reaching my goals?
- Am I on track to reach my objectives?
- How much money do I need to reach my goals and how much am I currently saving?
- What scenarios do I need to evaluate in order to make good decisions?
- When do I want to retire?
- How much do I need to save for college?
- Where do I stand with my assets, liabilities and cash flow and what area do I need to improve?

- Is my team of professionals working together and is everyone looking out for my best interests?
- What is an optimal asset allocation to help me achieve my objectives?
- Is my estate plan in order?
- Am I paying too much tax?
- Are my assets unnecessarily exposed to liability?
- What is the status of my insurance coverage? Do I need to same amount and type of coverage as I did in the past?
- What risks do I have to my career?
- How will my health impact my planning?

**Take the Next Step**

While the above list of questions is not comprehensive, it’s a great starting point. Start organizing your financial records and write down items that need to be addressed. Have a conversation with a spouse, partner or relative to make sure all members of your team are on the same page. And make sure you’re working with a qualified financial planner. A financial planner will help you gather information, analyze data, and come up with specific recommendations that will help you make progress towards your goals.

While it’s great to have everything in a written document, remember that financial planning is a process, not a one-time event. Personal and economic change will necessitate regularly updating your strategy – a key aspect of planning is to have regular reviews of where you stand.

If you don’t have a financial plan, now would be a good time to create one. If it’s been a while since you looked at your plan, it may be time for a review. If you are unsure where you stand, maybe it’s time for a second opinion. Don’t let the “busyness” of life prevent you from investing in yourself.

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

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**For More Information**

Want to avoid common investing mistakes? Request a copy of our white-paper *Eight Mistakes Physicians Make with Their Money and How to Avoid Them* by contacting co-author Jim Niedzinski at 888-958-1990 or download a copy from our website at www.wealthcareadvisors.com.
New MSMS Investment Fund Will Grow Medical Startups in Michigan

The Michigan State Medical Society is proud to announce the launch of its new startup investment fund Quantum Medical Concepts. The fund will provide capital for Michigan-based early stage medical companies.

“MSMS has several members who are already innovators in the medical field and some even hold patents for devices they have designed for their patients,” said Ben Louagie, chief operating officer for the Michigan State Medical Society. “Through Quantum Medical Concepts, we can help grow businesses that are on the forefront of health care innovation in the state while providing them access to more than 15,000 medical professionals in our network.”

Quantum Medical Concepts will seek to invest up to $250,000 across two to three medical startup companies per year. In addition to providing startup capital, Quantum will also offer management support for company founders through its partnership with Lansing-based startup management firm Common Wealth Enterprises.

“Company founders are often very knowledgeable in their field of expertise, but don’t have the time to focus on other important functions that are required to grow their businesses,” said Common Wealth Enterprises CEO Tom Stewart, whose company also runs the NEO Center business incubator in Lansing. “By offering support for those management functions that the founders lack, Quantum can increase the likelihood of success and minimize the investment risk.”

Money used to fund the Quantum investments comes from MSMS business revenue, rather than membership dues. Medical businesses funded by Quantum will undergo a needs assessment that analyzes their proficiency in core functions such as accounting and finance, human resources, operations and product development. Based on the needs identified by this assessment, Quantum will work with each company to design a program that guides its growth.

Quantum Medical Concepts will seek to invest up to $250,000 across two to three medical startup companies per year. In addition to providing startup capital, Quantum will also offer management support for company founders through its partnership with Lansing-based startup management firm Common Wealth Enterprises.

Quantum Medical Concepts provides early-stage investment funding to Michigan companies who have solid ideas for innovation in the medical sector. Our business model is unique – in addition to start-up funding, we provide active management support for our portfolio companies. This allows us to quickly identify and support products which have a high likelihood of success. We seek to invest in companies who are forward-thinking, energetic, and dedicated. And in doing so, we will realize solid returns for our investors.

Through a partnership of the Michigan State Medical Society and Common Wealth Enterprises, Quantum provides a unique business model. Our combination of capital, access to more than 15,000 medical professionals, and a proven startup management process grants us – and our portfolio of companies – a clear advantage.

Learn more at QuantumMedicalConcepts.com.
Attention Windows XP Users

Microsoft announced that on April 8, support and updates for Windows XP will no longer be available. As a result, after April 8, technical assistance for Windows XP will no longer be available, including automatic updates that help protect your PC and the information contained on it. While this may seem like an inconsequential announcement to most users, the impact may affect your HIPAA compliance status. When Microsoft retires a version of the operating system, they cease all updates to the software. The result of this is that future security vulnerabilities may not be addressed.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) regulates several aspects of health care delivery and payment. HIPAA and related regulations provide for uniform rules to protect the privacy and security of protected health information (PHI). Most people are very familiar with the HIPAA "Privacy Rule," which dictates when and to what extent PHI can be used and disclosed, as well as the provision of a covered entity's Notice of Privacy Practices to patients.

Less prominent than the "Privacy Rule," but equally as important, is the HIPAA "Security Rule." The Security Rule established a national set of security standards for protecting certain health information that is held or transferred in electronic form. Key elements of the Security Rule include who is covered, what information is protected, and what safeguards must be in place to ensure appropriate protection of electronic PHI (e-PHI). Physicians and other covered entities maintaining e-PHI must implement administrative, physical, and technical safeguards.

The lack of Microsoft security updates could impact your HIPAA security compliance. According to the Security Rule, a covered entity must implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e-PHI. Basically, this means that the operating systems and Protection from Malicious Software on workstations that process e-PHI must be updated with the latest security patches. You may notice, from time to time, that your Windows workstation will ask you to restart due to updates that have been installed. As software companies identify security vulnerabilities in the network or their applications, they issue updates to lessen or eliminate the vulnerability.

The impact to you is potential security vulnerabilities and HIPAA non-compliance. HIPAA prescribes frequent and necessary security updates in order to preserve the Confidentiality, Integrity, and Availability of Electronic Protected Health Information. HIPAA Citation 45 CFR 164.308(a)(5)(ii)(A), an addressable implementation specification, calls for periodic security updates, which includes software.

If you do not already have a plan to migrate to a newer version of Microsoft Windows, it is something you should consider sooner rather than later.

For additional information from Microsoft regarding their decision to no longer support Windows XP, visit http://windows.microsoft.com/en-us/windows/end-support-help.

Information for this article extracted from Health Care Management’s Quarterly HIPAA Briefing and Security Reminder, WPS Medicare eNews, and MSMS HIPAA Guide.

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Vaccination is a critical preventive health measure. Making sure your patients are up-to-date on vaccines recommended by the Centers for Disease Control and Prevention (CDC) ensures that they are receiving the best protection available from a number of serious diseases. The National Vaccine Advisory Committee (NVAC) recently revised and updated the Standards for Adult Immunization Practice to reflect the important role that all health care professionals play in ensuring that adults are getting the vaccines they need.

These new standards were drafted by the National Adult Immunization and Influenza Summit (NAIIS), which includes more than 200 partners, including federal agencies, medical associations, state and local health departments, pharmacists associations, and other immunization stakeholders.

What makes adult immunization a priority for leaders in medicine and public health? First and foremost, adult vaccination rates are very low. For example, rates for Tdap and zoster vaccination in the US are 20 percent or less for adults who are recommended to get them. Even high risk groups are not getting the vaccines they need – only 20 percent of adults younger than 65 years old who are high risk for complications from pneumococcal disease are vaccinated. In Michigan, pneumococcal coverage levels for individuals 65 years of age and older have remained stagnant the past five years and are well below the Healthy People 2020 target of 90 percent.

Each year, tens of thousands of adults needlessly suffer, are hospitalized, and even die as a result of diseases that could be prevented by vaccines. However, a recent national survey showed that most US adults are not even aware that they need vaccines throughout their lives to protect against diseases like shingles, pertussis and hepatitis.

Adults trust their health care professionals to advise them about important preventive measures. Most health insurance plans provide coverage for recommended adult vaccines; and research indicates that most patients are willing to get vaccinated if recommended by their doctor. However, most patients report their health care providers are not talking with them about vaccines, missing opportunities to immunize. Incorporating vaccine assessments into routine clinical care is key to improving vaccination rates.

The CDC is calling on all health care professionals to make adult immunization a standard of patient care in their practice by integrating four key steps:

1. **ASSESS** immunization status of all your patients in every clinical encounter. This involves staying informed about the latest CDC recommendations for immunization of adults and implementing protocols to ensure that patients’ vaccination needs are routinely reviewed.

2. **SHARE** a strong recommendation with your patients for vaccines that they need. Key components of this include tailoring the recommendation for the patient, explaining the benefits of vaccination and potential costs of getting the diseases they protect against, and addressing patient questions and concerns in clear and understandable language.

3. **ADMINISTER** needed vaccines or REFER your patients to a provider who can immunize them. It may not be possible to stock all vaccines in your office, so refer your patients to other immunization providers in the area to ensure that they get the vaccines they need to protect their health.

4. **DOCUMENT** vaccines received by your patients. Help your office, your patient, and your patients’ other providers know which vaccines they have had by participating in the Michigan Care Improvement Registry (MCIR, www.mcir.org). Entering all doses administered to individuals of all ages into MCIR is considered an immunization best practice. Remember, for the vaccines you don’t stock, follow up to confirm that patients received recommended vaccines.

For more information and resources to improve adult immunization practice, visit: www.cdc.gov/vaccines/hcp/adults

The 2014 Recommended Immunization Schedule for Adults Aged 19 Years and Older is available at: www.cdc.gov/vaccines/schedules/hcp/adult.html

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**For More Information**

1. National Health Interview Survey, 2012
Physicians Must Speak Up When It Comes to Immunizations

By Cindy Ackerman

Are physicians contributing to Michigan’s dismal immunization rate? Last year, nearly six percent of Michigan kindergarteners were unvaccinated, giving Michigan the fourth worst vaccination rate in the country.

Centers for Disease Control and Prevention Director Thomas Frieden, MD, MPH, states that a physician’s recommendation is “the single most important factor in a parent’s decision to vaccinate.” Then why are so many Michigan parents deciding to “opt out” of potentially life-saving vaccinations for their children?

Research published in Pediatrics found that most physicians (74 percent) are too ambivalent in their vaccination discussions with parents. The odds of parents objecting to vaccines was 17 times higher when the physician asked, “What do you want to do about shots for Johnny?” as opposed to “It’s time for Johnny’s shots.” However, 47 percent of the initially resistant parents ultimately complied when the doctor took a firm position.

In February, Pat Krehn, RN, BSN, addressed the MSMS Alliance. Ms. Krehn is a member of the Michigan Advisory Committee on Immunizations and the State Flu Advisory Board. She oversees the Immunization Program at Public Health-Muskegon County. Muskegon County has one of the best immunization rates in Michigan because parents seeking Immunization Waiver Forms must first report to the Public Health Department for vaccine education.

Ms. Krehn says parents are understandably suspicious of vaccines. Bombarded with misinformation from the internet, parents need to hear from a trusted health care provider that the benefits of vaccines clearly and definitively outweigh the risks. Parents need to hear that scientific advances over the past 30 years allow protection from twice as many diseases with a fraction of the immunologic components. Ms. Krehn says that parents need to hear that “some diseases are so common in this country, that the choice not to get the vaccine is a choice to get the disease.” When provided with factual information, based on well controlled, reproducible, scientific studies, parents are able to make sound decisions and most will choose to vaccinate.

Centers for Disease Control and Prevention Director Thomas Frieden, MD, MPH, states that a physician’s recommendation is “the single most important factor in a parent’s decision to vaccinate.”

Vaccines are the best defense against dangerous childhood diseases. Parents who “opt out” put their child at risk for illness and maybe even death. In 2012, Michigan baby Francesca lost her life to pertussis (whooping cough) at just 12 weeks old. Her mother believes that she was the one who infected her daughter. Franny’s symptoms began with a mild cough. She died nine days later.

Physicians and other health care professionals are powerfully influential. The Alliance is also preparing to weigh in on this debate. Armed with knowledge and an assertive approach, we all have the ability to educate parents who are unsure about vaccinations. By speaking out, our voices will trump the anti-vaccine movement in Michigan. It’s imperative for the protection of children and the health of others as well. After all, the study author noted, “There is no other medically accepted option.”

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
### Disciplinary Actions

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.


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<th>City, State</th>
<th>Violation</th>
<th>Action(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>43-01-087079</td>
<td>11/05/2013</td>
<td>Probation, Reprimanded</td>
<td>Ada, MI</td>
<td>Voluntarily Surrendered</td>
<td>Sister State Disciplinary Action</td>
</tr>
<tr>
<td>43-01-068026</td>
<td>11/20/2013</td>
<td>Probation, Reprimanded</td>
<td>Mexico, MO</td>
<td>Failure to report/Comply</td>
<td>Sister State Disciplinary Action</td>
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<tr>
<td>43-01-060835</td>
<td>11/20/2013</td>
<td>Probation, Fine Imposed</td>
<td>Dearborn Heights, MI</td>
<td>Failure to Report/Comply</td>
<td>Fine imposed</td>
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<td>43-01-057132</td>
<td>11/20/2013</td>
<td>Reprimanded</td>
<td>Harbor Springs, MI</td>
<td>Technical Violation of the Michigan PHC</td>
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</tr>
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</table>

#### 11/16/2013 – 11/22/2013

<table>
<thead>
<tr>
<th>License Number</th>
<th>Date</th>
<th>Approved License</th>
<th>City, State</th>
<th>Violation</th>
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</tr>
</tbody>
</table>

### 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.

**Reprimand** – 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 specified period of time.

**Summary Suspension** – if the actions a licensee are 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.

**Suspension** – 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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- BCBSM PGIP Webinar Series
Please visit website www.msms.org/eo for a complete listing.

Surviving and Thriving in an Environment of Reimbursement Reform
Date: Friday, April 25, 2014
Time: 1:30 p.m. to 4:45 p.m.
Location: The Henry, Dearborn
Contact: Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org
Intended for: Physicians, practice managers/administrators, and all other health care professionals

Conference on Child Obesity
Date: Tuesday, May 13, 2014
Time: 9:00 a.m. to 4:00 p.m.
Location: The Henry, Dearborn
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

Spring Scientific Meeting
Date: Wednesday, May 14, and Thursday, May 15, 2014
Location: The Henry, Dearborn
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

Annual Joseph S. Moore, MD, Conference on Maternal and Perinatal Health
Date: Thursday, May 15, 2014
Location: The Henry, Dearborn
Contact: Marianne Ben Hamza, (517) 336-7581 or mbenhamza@msms.org
Note: Continental breakfast and lunch will be provided
Intended for: Physicians, nurses, residents, students, and all other health care professionals working with women and infants

ICD-10-CM Boot Camp: The Clock is Ticking
Date: Thursday, May 1, and Friday, May 2, 2014
Time: 9:00 a.m. to 4:00 p.m.
Location: FireKeeper’s Casino, Battle Creek
Date: Thursday, June 5, and Friday, June 6, 2014
Time: 9:00 a.m. to 4:00 p.m.
Location: Weber’s Inn, Ann Arbor
Date: Thursday, August 21, and Friday, August 22, 2014
Time: 9:00 a.m. to 4:00 p.m.
Location: Great Wolf Lodge, Traverse City
Contact: Marcie Barnum, (517) 336-5724 or mbarnum@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians, billers, and coders

Welcome to These New MSMS Members

Eva Bieniek, MD, Washtenaw
Shawez Bokhari, MD, Calhoun
Craig Boss, MD, Charlevoix
Jason Calhoun, MD, Kent
Carl Harlan, DO, Charlevoix
Sven Hida, MD, Kalamazoo
Mary Ivey, MD, Charlevoix
Veena Kalra, MD, Flint Township
Kenneth Kozlow, MD, Kent
Henry Paul Lasky, MD, St. Clair
G. Robert Lesser, MD, Royal Oak
Eric Payne, MD, Calhoun
Deborah Smith, MD, Charlevoix
Roderic Tinney, MD, Charlevoix
Michael Tucker, Jr., DO, Saginaw
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Thursday, May 8, 2014  7:30 a.m. – 3:30 p.m.

COURSE DIRECTOR/MODERATOR
Marc L. Cullen, MD, MPH, FACS
Surgeon-In-Chief, St. John Providence Children’s Hospital Division Chief – Pediatric Surgery,
St. John Hospital and Medical Center, Detroit, MI

SYMPOSIUM

Innovations in Electronic Information – Improving Office Care
Ted Daniel, MD
Chief Medical Information Officer, St. John Providence Health System; Pediatrician, St. John Providence Children’s Hospital, Detroit, MI

Challenging ID Photo Cases: from the Mundane to the Memorable
Stanley L. Block, MD
Physician to Children and Adolescents, PSC; President of Kentucky Pediatric/Adult Research;
Professor of Clinical Pediatrics, University of Louisville; Professor of Clinical Pediatrics, University of Kentucky College of Medicine, Bardstown, KY

Calling the Neurosurgeon: Top Pediatric Consults
Abilash Haridas, MD
Pediatric Neurosurgeon, Children’s Hospital of Michigan, Detroit, MI;
Clinical Instructor of Neurosurgery, Attending Physician, University of Illinois/Chicago

Top 5 Endocrinology Concerns for the Office Pediatrician
Bassem Dekelbab, MD
Assistant Professor of Pediatrics, Oakland University William Beaumont School of Medicine, Wayne State University, Michigan State University;
Pediatric Endocrinologist, St. John Providence Children’s Hospital, Beaumont Children’s Hospital, Detroit, MI

5 Top Reasons for a Consultation to Pediatric Surgery
Marc L. Cullen, MD, MPH
Surgeon-In-Chief, St. John Providence Children’s Hospital; Division Chief – Pediatric Surgery, St. John Hospital & Medical Center, Detroit, MI

The Top Reasons Pediatricians Call for an Orthopedic Consult
Rick AK Reynolds, MD
St. John Orthopedic Pediatric Trauma, St. John Hospital & Medical Center, Detroit, MI

Top Ophthalmology Concerns in the Pediatrician’s Office
John D. Roarty, MD, MPH
Chief, Ophthalmology, Children's Hospital of Michigan; Assistant Professor, Ophthalmology, Wayne State University, Detroit, MI

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This symposium will be held at the Troy Marriott, 200 W. Big Beaver, Troy, MI 48084.

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

August 27, 2014 – Radiology Seminar
September 10, 2014 – OB/Gyn Seminar
October 22, 2014 – Family Medicine Seminar
December 3 2014 – Cardiology Seminar
March 4, 2015 – Surgery Seminar

For more information contact: 313-343-3877 as these may be subject to change.
Physicians – Doing Good Means Feeling Good
by Kenneth Elmassian, DO

When you are doing good, you feel good. That simple, even obvious, truth explains the motivations that sent us into medicine, and which keep us there, despite the increasing challenges physicians face. Research from the RAND Corporation finds that physicians who view themselves as delivering high-quality care express greater professional satisfaction. Those who felt stymied in delivering the highest quality of care (usually due to bureaucratic, reimbursement or regulatory constraints), however, claimed less satisfaction.

Those outside the profession likely aren’t too concerned about unhappy doctors, but there are deeper issues. As the RAND report observed, “when physician dissatisfaction is attributable to perceptions of quality problems, such dissatisfaction could be viewed as a ‘canary in the coal mine’ for the quality of care.” That is, if physicians are unhappy about the practice of medicine, “ain’t no one gonna be happy” – and that includes patients and society overall.

As RAND notes, physician attitudes are a valuable early warning of problems with health care. From staggering student loans at the beginning of careers to the reimbursement nightmares you face in the office today, medical practice as a ticket to big money seems pretty dubious. You and I both know that what really makes us happiest is not income, but the satisfaction of knowing we’re helping people get better, of making a measurable difference in longer, healthier lives.

There is an important, if less obvious, corollary to this view. Of all the players in the great, widely-defined health care system, we are the ones who most define ourselves as caregivers who can make a difference in a patient’s well-being, and make it a personal mission. Another recent survey, this one from Rutgers, polled various players in health care about their priorities. For physicians, number one was patient safety/quality of care.

There is one player in the continuum of modern American health care who personally looks out first for the welfare of patients: you and me, their physicians. There are two lessons we can take away from this. First, there’s the humanizing lesson that happiness comes from what we give to others, not what we accumulate. It was this impulse, this love of helping others, that sent us into this career, and it’s crucial for us to remind ourselves of it regularly. We’re physicians first and foremost because we want to be, because it helps us rest our heads on our pillows more easily at the end of the day to know that we’ve done something good for others.

The second lesson directly ties into this. Do your life, your attitudes, and your words reflect this joy in healing? Do your children hear mom or dad talk about the minor miracles you had a hand in today? Or do they just hear you grumbling about the hour you spent on the phone arguing with an insurer for pre-approval, or a with policymaker about the frustrations with health care reform?

Bringing joy to the practice of medicine ripples out to others in ways that can ultimately improve care. Patients will sense a zest for healing. Physicians increasingly serve as leaders of their organizations. If the members of your team view you as an inspiring leader, they become more inspired themselves. And policymakers, politicians, and community members pick up their health care messages from you. Will they view health care today as a costly, compromised boondoggle, unworthy of support or funding? Or will they view it as a valuable, innovative investment, focused first and foremost on quality patient care? You may discover the answer by looking into a mirror.
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