Case Studies Examine Child Obesity Assessment & Management in Physician Practices

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Physician Payments Sunshine Act Is Now Final

By Daniel J. Schulte, JD

**QUESTION:**
It has been a while since I have heard anything about the Physician Payments Sunshine Act. Has this law become final? When will payments, gifts, etc., to physicians become reportable? When will the public begin to have access to this information?

**ANSWER:**
The Centers for Medicare and Medicaid Services (CMS) issued the final rule implementing Section 6002 of the Affordable Care Act, commonly known as the “Physician Payments Sunshine Act” (the “Act”) on February 1, 2013. The effective date of the rule is April 9, 2013; however, the applicable manufacturers and group purchasing organizations (who the Act requires to collect and report data) are not required to begin collecting data until August 1, 2013, and they do not have to report this data to CMS until March 31, 2014. The data collected will first be made publically available by CMS on September 30, 2014.

Generally, the Act requires an applicable manufacturer to report payments or other transfers for value to covered recipients annually. The Act also requires applicable manufacturers and group purchasing organizations to report certain ownership or investment interests held by physicians and their family members in applicable manufacturers and group purchasing organizations.

Applicable manufacturers include any entity engaged in the production, preparation, propagation, compounding or conversion of drugs, devices, biologicals or other medical supplies. The definition of applicable manufacturers does not include distributors or wholesalers.

Covered recipients include physicians, dentists, podiatrists, optometrists and chiropractors. Teaching hospitals (i.e., any institution receiving indirect medical education payments, graduate medical education payments, etc.) are also included in the definition of covered recipients.

The payments or other transfers of value that must be reported include cash or cash equivalents, in-kind items or services, stock, stock options or any other ownership interests, dividends, profit interests or any other form of return on investment.

Valuing payments or other transfers for value will not always be a simple matter. The final rule clarifies some of the questions raised during the comment period leading up to the final rule:

1. Payments or other transfers of value will be reported as though made to a covered recipient when that covered recipient designates the payment or transfer for value be made to someone else.
2. Even if a covered recipient does not make a formal request for a payment or transfer of value, it still must be reported.
3. A payment or transfer of value to a group practice will be attributed to the individual physician covered recipient who requested the payment or on whose behalf the payment was made or who is intended to benefit from the payment or transfer of value.
4. Meals provided in a group setting will result in the reporting of the per-person cost of the food/beverage for each covered recipient who actually partakes in the meals.
5. The following payments or transfers of value are excluded from reporting:
   a) De minimis amounts (i.e., less than $10 or $100 depending on the nature of what is being provided)
   b) Materials being provided for the direct benefit of patients or that are intended for patient use (e.g., anatomical models or wall models provided to help explain procedures to patients)
   c) Discounts and rebates
   d) Product samples not intended to be sold and intended for patient use

The final rule requires applicable manufacturers to report fairly detailed information any time a payment or other transfer for value to a covered recipient is made. The information required to be report includes the name, business address, specialty and NPI of the covered recipient; the date of payment; the name of the drug, device, biological or medical supply associated with the payment; the form of payment; and the nature of the payment (e.g., consulting fee, compensation, honoraria, gift, entertainment, etc.).

This data collected by CMS will be made available on a publically accessible website beginning in September 2014. The first data publication in 2014 will cover the data collected for 2013.

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: Jessy Sielski, Michigan Medicine, MSMS, 120 West Saginaw Street, East Lansing, MI 48823, or at jsielski@msms.org.
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Case Studies Examine Child Obesity Assessment and Management in Physician Practices

By Jacquie LaFay

The Michigan State Medical Society, along with the Michigan Chapter of the American Academy of Pediatrics – recently released a series of case studies profiling pediatric and family practitioner practices, school-based programs, and other settings to capture the experiences of Michigan physicians and their partners as they assess and manage children with obesity.

Conducted by Public Sector Consultants Inc. (PSC), a Lansing-based public policy research firm, the case studies were intended to provide physicians with a variety of practical examples of assessment and treatment that would be applicable to their own practices. The practices recruited to participate in this study were selected to obtain a diverse group of physicians, with varied practice size, practice location (urban, rural, suburban, regions of the state), successes, and struggles.

The following is one of the seven case studies, printed in its entirety. To download all the case studies, visit www.msms.org/obesity.

To request a printed copy, contact Caryl Markzon at 517-336-7575 or cmarkzon@msms.org.

Practice Profile – St. Joseph Pediatrics

St. Joseph Pediatrics is located in Tawas City, Michigan. This practice serves not only families of Iosco County, but also sees patients in the surrounding seven counties (including Alcona, Arenac, Ogemaw, and Oscoda). St. Joseph Pediatrics employs four staff to serve its 2,800 children and adolescents: one full-time physician, a part-time nurse practitioner, and two part-time medical assistants. The practice has been a Blue Cross Blue Shield of Michigan (BCBSM) designated patient centered medical home within the St. Joseph Health System since 2010.

PSC spoke with three people during its visit to St. Joseph Pediatrics: Joanna Studley, MD; nurse practitioner Tana McKulsky, RN, MSN; and medical assistant Debbie Finley.

Assessing and Managing Treatment of Child Obesity

Doctor Studley, called “Doctor Jo” by those in her community, began practicing in Tawas City six years ago upon finishing her residency in Columbus, Ohio. Doctor Studley was exposed to the issue of obesity throughout her residency. She and her staff began to notice the appearance of overweight and obesity among adolescent or “tween” patients and sought to focus on the issue. McKulsky began to look at patient data to confirm their speculation that their adolescent patients were getting heavier and to look for trends in their patients’ growth. As the physician and her staff had begun to address obesity with their older patients, they decided to start prevention efforts with their youngest patients.

Assessment

Doctor Jo and her staff assess all of their patients between 2 and 18 years of age for obesity during annual well-child or acute care visits. To assess a child’s risk for obesity, they use information gleaned from the patient intake form, a risk assessment survey (BCBSM’s 5-2-1-0 brochure), and the standard child growth chart. The combination of information collected using these tools helps them to assess a child’s family history, physical health, lifestyle, and environment. In addition, Doctor Studley and Ms. McKulsky also assess a child or parent/caregiver’s readiness to make changes in their lifestyle and barriers to achieving a healthy lifestyle.

Family History: The child’s family history is captured on new patient intake forms and collected for all patients beginning with the practice. Patients are asked for any changes that need to be made to the family history during subsequent visits. Adolescent children complete a questionnaire asking for more detail about history of high blood pressure, diabetes, and cholesterol when they visit the office. The physician and nurse practitioner at this practice have found family history, especially related to obesity, a delicate topic to discuss with parents/caregivers. Ms. McKulsky said, “It can be a touchy situation to address the risks of obesity with a parent who is obese to help their child not to become obese.”
Physical Health: A complete physical examination is conducted during each well-child visit. The standard child growth chart is used to measure a child's height and weight to determine if a child falls within the 5th and 85th percentile range. According to the Centers for Disease Control, above the 90th percentile is considered overweight and above the 95th percentile is considered obese. They check the child's heart, lungs, ears, nose, throat, and circulation, and how well a child is able to move. In addition, lab tests for diabetes and lipid profiles are conducted for children with a high-risk family history or if they are over the 97th percentile in height and weight. The information from the physical examination is used to present objective information to the child and parents/caregivers to help them understand what is happening with the child's body and to encourage them to make changes in their lifestyle.

Lifestyle and Environment: A child and/or family's lifestyle is assessed using the BCBSM's 5-2-1-0 Program brochure. Parents complete the survey in the brochure and the physician or nurse practitioner discusses their responses with them during the office visit. Adolescents are asked to answer the survey themselves. “I find we get different answers from parents than we do children,” McKulsky said. For example, parents may feel that their child is getting five servings of fruits and vegetables a day, but when children as young as four or five years old are asked they cannot think of what fruits or vegetables they eat on a regular basis. Other questions on the brochure help to fuel discussion with the family and child about time spent watching television, playing video games, or on the computer; how many “screens” are in the home and where they are located (e.g., whether any are in the bedroom or kitchen); participation in sports or gym class; whether a family eats meals together; and consumption of sugary-sweetened beverages. In addition to the BCBSM 5-2-1-0 survey, the physician and nurse practitioner talk to parents/caregivers about the kinds of activities and food the child gets while away from home, such as at school, child care, or the home of grandparents or other family caregivers. They help parents learn how they can be an advocate for their child's health in the various environments the child is in during a day.

Readiness to Change: The nurse practitioner at St. Joseph Pediatrics assesses whether a child and/or family is ready to make changes to their lifestyle. Children are asked, based on a scale of 0–10, if they are happy about their weight. If they end up in the middle, the nurse practitioner encourages them to be more interested in their health by asking why they came in for the visit, or whether there is any one thing they might be able to change. She said, “Sometimes they may think they have to change a lot, more than just one thing. Often, they are willing to change one thing.”

Managing Treatment
Once a child is identified as obese or overweight, the physician and nurse practitioner provide counseling and a variety of supports to help each child meet his/her goals. The nurse practitioner helps the child or family create one attainable goal that the child feels ready to attempt. This could include eating more vegetables, not drinking sports drinks, beginning to take walks, or playing outside every day. The child returns a month later to be weighed, to talk about the progress toward meeting the goal, and to set additional goals. At each monthly visit, the nurse practitioner or physician provides a variety of resources.
A complete physical examination is conducted during each well-child visit. The standard child growth chart is used to measure a child’s height and weight to determine if a child falls within the 5th and 85th percentile range. According to the Centers for Disease Control, above the 90th percentile is considered overweight and above the 95th percentile is considered obese.

**Addressing Barriers**

Barriers to attaining healthy goals come out through discussions with the child and their parent/caregiver as the child’s goals are set. Doctor Studley said, “People feel limited in terms of what they could do.” For example, there may be fewer opportunities for outdoor activity during the winter, or purchasing healthier foods may be more expensive than less healthy choices. Doctor Studley and her staff keep abreast of various inexpensive or free activities offered in the area (e.g., community center open gym night) or they talk with the family about what they could do together outside to increase physical activity. In addition, they talk about economical ways to purchase healthier food at a farmer’s market or by planting a garden at home.

The most common barriers that Doctor Studley and her nurse practitioner have had to help families overcome are related to limited resources and the environment. For example, if patients with limited resources are unable to make follow-up visits to St. Joseph Pediatrics because they have to travel a long distance, the physician might encourage the parent/caregiver to get a scale to use at home to monitor the child’s weight and schedule fewer office visits. Environmental barriers they have had to address with their patients include brainstorming what children can do outside if their neighborhood isn’t safe, or during the cold, snowy, winter months. The physician and nurse practitioner talk with families about activities they could do at their home (such as playing ball outside in the yard) and classes offered at community facilities. They also encourage the parents to get outside and play with their children, to be positive role models and help encourage their children. Doctor Studley is also trying to work with some of the schools and area day care centers to educate them on the BCBSM 5-2-1-0 program to help address issues outside of the home environment.

Although St. Joseph Pediatrics patients are not diverse in race or ethnicity, the practice has had to deal with cultural barriers such as family traditions and generational differences. A number of children served by the practice come from farming families or are taken care of by grandparents. These families follow longstanding family traditions that include a lot of “meat and potato meals.”

Parents/caregivers may require a child to “clean their plate” even if the child is full, or use food as a reward. McKulsky told a story about a boy who was well on his way to meeting his health goals but had a hard time when he stayed at his grandmother’s house.

He told the nurse practitioner, “My mom helps me get frozen fruits and vegetables, but when I am at my grandma’s [house] she has frozen candy for me to eat.” To address these issues, the physician and nurse practitioner provide objective health information to the families to show them how the family’s diet is affecting the child’s health, followed by counseling and information to make small changes in their lifestyle.

**Staff Utilization and Training**

In addition to the physician and nurse practitioners, there is a medical assistant who helps with patient care. She administers the obesity risk assessment, measures height and weight, and helps to encourage and support children and their families. Both the physician and the nurse practitioner have attended numerous conferences and training sessions. They also keep abreast of research in the health literature. Doctor Studley most recently attended a conference focusing on child obesity offered by Pew Research in Washington, DC. That conference dealt with how to address school nutrition and provided information on the new school nutrition guidelines for competitive foods (such as vending machines) and the new nutrition standards for school lunches. The nurse practitioner at St. Joseph Pediatrics has received training on self-management. This training has helped her to gain skills to assess a child’s readiness to make changes and help him/her set goals for health improvements.

**Office Culture and Environment**

Since Doctor Studley’s focus on obesity prevention, lollipops were replaced with stickers and other trinkets for children to receive after getting a shot. She also removed the TV from the waiting room and set an office policy not allowing staff to have soda and other sweetened beverages on the premises. Doctor Studley and her staff want to be role models for the families they treat. Posters and information hang in the waiting room and in each examination room displaying information on healthy eating and physical activity. One of the most popular resources provided to families is ChopChop magazine. In addition to handing out this family-friendly, healthy cooking magazine during obesity counseling sessions, copies are available in the waiting room. Doctor Jo said that mothers will come into the office just to pick up the most recent copy. The physician and nurse practitioner both said that more often than not when they enter an examination room the parent and child are discussing the information on the posters. They said having that information posted makes it easier for the physician or nurse to begin a discussion about healthy lifestyles.

**Reimbursement**

St. Joseph Pediatrics is part of a patient centered medical home through the St. Joseph Health System. The physician and nurse practitioner said that aside from the well-child visit code, they do have other codes they use to bill for services, including an obesity diagnosis code, and treatment codes for nutritional evaluation and surveillance, and counseling for initial and ongoing visits with a patient. The codes they use to bill have been provided by the various Medicaid HMOs, through which many of their patients are insured. They were not able to provide input on insurer incentives and payments, as that is monitored by the hospital billing department.

**Community Involvement**

The staff at St. Joseph Pediatrics is heavily involved in the community, and has taken the initiative to engage community
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partners to help address child obesity. Two National Initiative for Children’s Healthcare Quality (NICHQ) programs, Collaborate for Healthy Weight and Be Our Voice,1 have helped prepare Doctor Studley and her staff through online training sessions to engage community partners in addressing child obesity. Doctor Studley has engaged school food service directors, early childhood organizations, and local government agencies (such as WIC, parks and recreation) to share information on child obesity and talk about how they can help respond by each sending families similar messages. In addition, Doctor Studley has partnered with a local grocer to provide signage for families to find healthier food options. Doctor Studley created a “Doctor Jo Approved” shelf tag to help children and families while shopping at this grocery store. Most recently, the grocer transformed one check-out lane by removing the candy from the shelves, replacing it with fresh fruits and vegetables and other healthy food options.

In addition, Doctor Studley has written articles for the local newspaper and the hospital newsletter, and has participated in interviews on a local radio show and local library summer reading activities focused on healthy eating. She and her staff participate in community health fairs and school events, and pass out healthy lifestyle trinkets (like jump ropes) during local parades.

**Lessons Learned**

Keeping things positive is the most valuable lesson St. Joseph Pediatrics has learned while staff work with families to address child obesity. Obesity is a delicate and sensitive issue for children and their families alike. The nurse practitioner said focusing on small steps that children and families can take to make changes and see positive outcomes quickly has helped to motivate them to make more changes. In addition, Doctor Studley said being seen outside of the office is important, too. She said, “I think being involved in the community is huge. The practice is associated with healthy eating. People know when they come in we are going to talk about it.” The nurse practitioner said that the most challenging aspect of treating child obesity is getting people to eat fruits and vegetables. She said, “That itself is a culture change.”

The author is Consultant for Health Policy at Public Sector Consultants, Inc., a public policy research firm.

1BCBSM’s 5-2-1-0 program was adapted from best practices from the Centers for Disease Control and Prevention and Blue Cross Blue Shield companies by the Blue Cross and Blue Shield Association as part of the “Good Health Club Physician Tool Kit” (available online at www.bcbs.com/healthcare-partners/good-health-club-toolkit/good-health-club-physician.html).

2The Michigan Nutrition Network “facilitates the development of effective, high-quality nutrition and physical activity initiatives and partnerships targeting people eligible for the Supplemental Nutrition Assistance Program (SNAP)” (www.michigannutritionnetwork.org/).

3The Collaborate for Healthy Weight initiative encourages the engagement of primary care providers, public health professionals, and community-based organizations to implement best practices for quality improvement to reduce obesity (www.nichq.org/our_projects/prevention_centerHealthyWeight.html). The Be Our Voice initiative of the NICHQ is supported by the Robert Wood Johnson Foundation. The initiative trains healthcare professionals to become advocates for improved policies in their communities to reverse the trends in child obesity (www.nichq.org/advocacy/index.html).
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What he meant was that insisting on perfection often results in no improvement at all, and therefore, it is a fruitless pursuit. This is an important maxim to keep in mind when it comes to legislative advocacy.

It's impossible to create a perfect law in Lansing — one that magically benefits every last citizen in the state at no cost while simultaneously satisfying the interests of more than 15,000 individual physicians. It just ain't gonna happen. But as an organization, MSMS would be a failure if it didn't keep striving to improve health care in Michigan by passing good policy.

Member input, particularly through county and specialty medical societies, is what gives MSMS the framework for its legislative agenda every year and helps MSMS's legislative advocacy team stay focused on the health policy issues that will benefit physician practices in Michigan the most. In return, MSMS gives physicians a collective voice, strength, and support during medicine's most turbulent times.

Here’s a look at what’s happening with this year’s hot issues, some of which are still pending:

**Universal Prior Authorization**

Michigan physicians and patients scored a big victory on May 16 when Gov. Rick Snyder signed Senate Bills 178 and 179 into law, which create a universal prior authorization form for prescription drugs.

The bills, championed for years by MSMS, state Sen. Tonya Schuitmaker (R-Lawton) and state Rep. Gail Haines (R-Waterford Twp.), were born in response to calls from Michigan physicians to improve patients’ access to the best care.

“Michigan physicians and their staffs want to be in the exam room with patients, not chained to their desks sorting through hundreds of different versions of the same basic form,” said MSMS President Kenneth Elmassian, DO, in a statement. “Governor Snyder and lawmakers sent a clear message to families across the state that when it comes to health care, patients come first.”

MSMS Secretary Rose M. Ramirez, MD, a former nurse, made the case to the Senate Reforms, Restructuring & Reinventing Committee for voting “NO” on Senate Bill 2.

**Nurse Scope Expansion**

MSMS Government Relations staff and lobbyists have been advocating tirelessly at the Capitol on Senate Bill 2, introduced by Sen. Mark Jansen (R-Grand Rapids), which aims to change the Public Health Code to allow a sweeping expansion of scope of practice for advanced practice registered nurses.

MSMS Secretary Rose M. Ramirez, MD, a former nurse, represented physician opposition to the bill at a Senate Reforms, Restructuring & Reinventing Committee hearing in April: “As physicians, our overarching concern is with the well-being of our patients and that the laws and regulations of Michigan lead to health care that is safe, efficient, and of the highest quality.”

In addition to communication vehicles such as Medigram, the website and social
media, MSMS has continued its full-court press on this issue by putting together an op-ed column by Doctor Elmassian, and co-signed by physicians in targeted senate districts. Also, MSMS has been urging members and other friends of medicine – our grassroots network – to call their senators and use the MSMS Action Center to send electronic messages.

**Medicaid Expansion**

Legislative leaders have met the targeted budget deadline of June 1, but Medicaid expansion is not included, as those talks will continue. On one side, the Expand Medicaid coalition, of which MSMS is a member, is working to expand Medicaid eligibility and bump the program's rates to that of Medicare, as proffered in the Affordable Care Act. This initiative is supported by the Governor. If adopted, the expansion would cover approximately 450,000 additional lives.

Doctor Elmassian represented MSMS during a kick-off news conference for the Expand Medicaid coalition in February: “If we do not seize the opportunity in front of us – to expand coverage and improve access to essential health care services – we would be doing a great disservice to our state and to our patients.”

Representative Matt Lori (R-Constantine) recently introduced House Bill 4714, which puts reforms in place that would change the way able-bodied adults can receive Medicaid assistance by putting restrictions on access, among other things.

MSMS worked with the coalition to garner news coverage from major dailies and TV stations around the state. In March, MSMS brought members of its International Medical Graduate section to Lansing to lobby for this and other issues.

**Auto No-Fault Reform**

Recently, the House Insurance Committee passed House Bill 4612, introduced by Committee Chair Rep. Pete Lund (R-Shelby Twp.). The bill will essentially gut Michigan’s model auto no-fault law and replace it with a dangerous system that relies instead on expensive lawsuits, higher health insurance premiums for families and a cost shift from insurance companies onto the state’s cash-strapped Medicaid system. MSMS, as part of the Coalition Protecting Auto No-Fault (CPAN), strongly opposes the measure. CPAN President John Cornack made the case against auto no-fault reform in a March/April Michigan Medicine article.

**Graduate Medical Education**

MSMS’s considerable efforts working with key lawmakers in Lansing, including Sen. John Moolenaar (R-Midland), Chair of the Senate Appropriations Community Health Subcommittee, have paid off as GME avoided cuts. A perennial budget chopping-block favorite, GME funding faced a 7 percent cut in the governor’s proposed budget. And although it won’t see any increases, this is a big victory for the medical community as we work to keep physicians in Michigan and avoid the impending shortage. In March, MSMS brought students from three Michigan medical schools to Lansing for Student Lobby Day to push for GME funding. At the federal level, MSMS and the AMA
are supporting bills in the US House and Senate that will help meet the nation’s increasing demand for new physicians by funding an additional 15,000 Medicare-supported graduate medical education (GME) positions over the next five years.

**Patient’s Right To Know**
MSMS helped launch new legislation in April introduced by Rep. Gail Haines (R-Waterford Twp.) that requires medical professionals to wear and display their credentials both in the office and/or hospital, as well as in any advertising promoting their services. Nicknamed “Patient’s Right to Know,” the bill aims to empower patients by giving them the most accurate information about whom is treating them and what their health care provider is trained and licensed to do. Doctor Elmassian and Rep. Haines delivered a joint televised message to news media in April, and Doctor Elmassian also gave a radio interview and testified before the House Health Policy Committee, which Rep. Haines chairs.

**Indoor Tanning**
MSMS hosted a news conference in March to emphasize the importance of passing bills that would ban minors from indoor tanning facilities. Speakers included Michigan Dermatological Society Immediate Past President and MSMS member Kay Watnick, MD; Anne Goulet, Doctor Watnick’s patient who began tanning in her teens and was diagnosed with skin cancer at age 19; and Rep. Jim Townsend (D-Royal Oak), who sponsored HB 4404 and 4405. “Using a tanning bed is particularly dangerous for younger users. We have a responsibility to protect our children and we encourage lawmakers to pass these potentially life-saving reforms as soon as possible,” said Doctor Watnick.

**Expedited Partner Therapy**
MSMS helped coordinate, along with several other health organizations and state lawmakers, a news conference in May to support a bill that would promote expedited partner therapy (EPT), which is the practice of treating the sex partners of persons with the sexually transmitted diseases chlamydia and gonorrhea without an intervening medical evaluation. Representative George Darany (D-Dearborn) reintroduced HB 4736 from last year at the urging of many public health physicians in Michigan. Health Policy Committee Chair Rep. Gail Haines (R-Waterford Twp.) also supports the measure.

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

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Recently, the US Department of Health and Human Services (HHS) launched an initiative called Mobile Devices: Know the RISKS. Take the STEPS. PROTECT and SECURE Health Information. As part of its initiative, HHS has compiled a set of online tools and tips on ways to physicians and other health care providers can protect their patients’ protected health information when using mobile devices such as laptops, tablets, and smartphones.

“We know that health care providers care deeply about patient trust and the importance of keeping health information secure and confidential,” said Leon Rodriguez, director of the HHS Office for Civil Rights. “This education effort and new online resource give health care providers common sense tools to help prevent their patients’ health information from falling into the wrong hands.”

HHS offers the following tips to help you secure the health information your patients entrust to you:

1. Install and enable encryption to protect health information stored or sent by mobile devices.
2. Use a password or other user authentication.
3. Install and activate wiping and/or remote disabling to erase the data on your mobile device if it is lost or stolen.
4. Disable and do not install or use file-sharing applications.
5. Install and enable a firewall to block unauthorized access.
6. Install and enable security software to protect against malicious applications, viruses, spyware, and malware-based attacks.
7. Keep your security software up to date.
8. Research mobile applications (apps) before downloading.
9. Maintain physical control of your mobile device. Know where it is at all times to limit the risk of unauthorized use.
10. Use adequate security to send or receive health information over public Wi-Fi networks.
11. Delete all stored health information on your mobile device before discarding it.

Several frequently asked questions (FAQs) are also addressed on HHS’s Mobile Device Privacy and Security website such as:

**Do you need to comply with HIPAA if you are using a mobile device?**

If you are a covered entity or a business associate, yes. HHS OCR has detailed information explaining who is a covered entity. In general, individuals and organizations that meet the definition of a covered entity, namely those who are health plans, health care clearinghouses, or health care providers who transmit health information in electronic form in connection with certain transactions must comply with the Rules’ requirements to protect the privacy and security of health information, even when using mobile devices. Their business associates are also contractually required to follow these requirements.

**What are some risks to know about before using a mobile device for patient care?**

Risks (threats and vulnerabilities) vary based on the mobile device and its use. Some risks may be:

1. A lost mobile device
2. A stolen mobile device
3. Inadvertently downloading viruses or other malware
4. Unintentional disclosure to unauthorized users when sharing mobile devices with friends, family and/or coworkers
5. Using an unsecure Wi-Fi network

Please visit the Mobile Device Privacy and Security website at www.HealthIT.gov/mobiledevices to view additional FAQs, as well as other educational resources including fact sheets and video tutorials.
‘The Team, the Team, the Team’
That’s What Managing Population Health is All About for Matthew Davis

By Stacy Sellek

The late Bo Schembechler may have famously uttered it, but Matthew M. Davis, MD, firmly believes in it. “That’s what it’s all about for me,” he says, just a few weeks into his new position as Chief Medical Executive for the Michigan Department of Community Health (MDCH). “The thing I really see as instrumental is to have a team, and one thing I’ve learned very quickly in the Department of Community Health is how strong the team is. I’m learning a lot very fast, and that’s attributable to the strength and the skills of that new team I’m a part of.”

So who is this new player on Michigan’s public health team?

A graduate of Harvard Medical School, Doctor Davis is responsible for coordinating Michigan’s public health initiatives and policy. He also will serve as a link between MDCH and the medical community, providing outreach and encouraging partnerships. He also currently serves as an associate professor of public policy at the University of Michigan Medical School and the Gerald R. Ford School of Public Policy, and is a founder of the C.S. Mott Children’s Hospital National Poll on Children’s Health. Doctor Davis, who is board certified in pediatrics and internal medicine, feels it’s important to keep practicing in the primary care role “to understand what it’s like to receive health care in this state.” In addition, he carries a master’s degree in Public Policy from the University of Chicago.

When he addressed the MSMS Board of Directors in April, Doctor Davis explained to his colleagues that his role as chief medical exec is to make sure physicians are at the table when it comes to policymaking. He emphasized to them, “You have a clinician and a partner in Lansing.”

One might say that Doctor Davis showed interest in the position long before he filled it. “Going back about 10 years ago, I started getting involved more in research projects that would help the state understand effective ways to assess programs, new and existing,” he says. “Some were state-sponsored projects and some were more informal. I found that very gratifying to make a difference for such a large population.”

Even his hats wear hats
To describe Doctor Davis based on what he does is exhaustive – and impressive: primary care physician; public policy expert; researcher; professor; leader; lecturer; author; volunteer; and the list goes on.

How and why would someone with this many irons in the fire take on such a publicly demanding role?

“The key reason I’m doing this is that I’ve wanted, for as long as I’ve been a doctor, to have an impact on population health. And there are many ways to do that,” explains Doctor Davis. “For several years, I tried to do research projects that were as timely and relevant as possible. I thought I should try this to see if I can improve the population’s health more directly through the Department of Community Health.”

He does admit that he has had to step down for a few other responsibilities in order to take on his new role. “I have these two hats that I wear – in Lansing and in Ann Arbor – that are very distinct. In terms of the chief medical executive role, I’ve very much been in listening mode to understand the different objectives and responsibilities of the department and of this role, in particular, and how they connect into the superb professionals in the Department of Community Health.”

TO HIS COLLEAGUES:
“MSMS is at the top of the list when we talk about collaborating to advance public health in Michigan. There are ways you can be effective on the issues in your own communities. For example, your voices are critically important to your patients; use them.”
“My goal is to bring the perspectives of the public into the policy dialogue. Now as a person in that policy dialogue, I have a chance to bring the public voice in even more directly, which is very exciting.”

— Matthew M. Davis, MD

Health,” he says. “I’ve been so impressed with the high caliber of their work and their deep commitment to the population health of the state.

“I also have been involved in what I would call ‘in the moment’ conversations where an immediate public health question comes up,” he continues. “And we must get together as a team to figure out what the most appropriate answer is. That combination of ongoing responsibilities and the spur of the moment role is one of the main reasons I took this position.”

Living in a patient centered medical home

Adding another descriptor to the long list above, Doctor Davis also refers to himself as a “connector.” One of his main jobs at MDCH is to essentially be the glue that brings together four main policy areas: behavioral health; population health; services to the aging; and Medicaid.

He told MSMS Board members that one of MDCH’s main goals is to rebuild the health care team in Michigan by using the patient centered medical home model – “single home, as a coordinated effort,” as he puts it.

This will enable the state to help people manage their health better, especially chronic health conditions, as well as draw upon existing resources and programs in a time of tight budgets, he explains.

With all that he is working on, Doctor Davis understands the importance of managing stress and keeping balance in his life.

He says, “I treasure time with my family,” which includes a daughter and son, 15 and 10 respectively, and his wife, Lakshmi Halasyamani, MD, who can relate to his new role. She serves as chief medical officer for St. Joseph Health System in Ann Arbor. “My wife and I share the high points and low points together.”

Doctor Davis’s team approach and work-life balance may truly represent the ultimate example of a “patient centered medical home.”

BOSTON STRONG

Doctor Davis, who trained in the Boston area and lived there for years, still has strong personal connections to the area and talks about the recent tragedy:

“Fortunately, no one in my family or close friendship network was there [at the marathon], but people I went to residency with were in the emergency departments when the victims rolled in. Although it was difficult, they’re trained for that moment.”

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Be in the Know about Legal Aspects of ACOs

Physicians need to become familiar with a variety of issues relative to accountable care organizations (ACOs) under the Medicare Shared Savings Program so they can make informed decisions about whether to participate, or wait and see if these organizations take root. MSMS has created a new Legal Alert exclusively for members called “What Physicians Need to Know about Accountable Care Organizations under the Medicare Shared Savings Program.” Download at www.msms.org/hcd.

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You could be trained in another specialty, or completely switch careers—and still receive full disability benefits—if you have disability coverage from MSMS Physicians Insurance Agency through Ameritas Life. With own occupation definition of total disability coverage, you would be considered totally disabled if you could not perform the duties of your Board Certified specialty, provided you were working in that specialty immediately prior to your disability. So, even if you went to work in another specialty, or did a different type of work altogether, you still would be considered totally disabled—and full benefits would be paid to you.

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If you’re faced with a malpractice lawsuit, you may feel that the entire litigation process – from discovery to trial – is beyond your control. But there is one very important element that you can control: your own testimony. Because the courtroom differs from the exam room or the surgical suite, and because opposing counsel’s job is to attempt to discredit you, being prepared is a must.

Physicians can start the preparation process by reviewing these basic tips before testifying:

1. Limit Your Answers
   Whether you’re on the witness stand or in a deposition room, your only obligation is to answer the question you were asked. You may be tempted to provide additional information that you think is relevant, but you could inadvertently harm your case. Stay within the scope of the question. Your attorney – not you – has responsibility for making sure that all relevant information is introduced.

2. Provide a Careful, Precise Answer
   When you answer precisely, you remove ambiguity from your testimony. But be sure not to box yourself in. If you are asked for a complete list of your actions, answer carefully. Unless you are absolutely sure you’ve provided every element, leave the list open. For example, if you are asked to detail the steps you took before arriving at a diagnosis, it is acceptable to say, “At this time, these are the steps I remember taking.”

3. Stay Calm
   Keep your cool. You lose credibility when you become sarcastic, raise your voice, or get defensive. Opposing counsel may try to provoke you. Don’t take the bait. If you can feel your blood pressure rising, pause for a moment to collect yourself before answering the question.

4. Be Straightforward
   The facts will come out in your deposition or at trial, so there is no point in trying to avoid an admission, even if you think that making it will hurt your case. When opposing counsel asks a question, don’t obfuscate. Quickly provide a clear answer. Dancing around the issue will only give it more prominence.

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 risk tips, patient safety tips, and physician practice tips, visit www.thedoctors.com/patientsafety.

For More Information

The Doctors Company provides Litigation Education Retreats as an exclusive benefit for members facing claims. At these one-day seminars, litigation experts offer essential advice about what makes a winning case, and physicians learn the skills necessary to aid in their own defense. Find more information at www.thedoctors.com/LER.
Lowering portfolio volatility, as opposed to simply maximizing returns, has proven to be more effective for maintaining wealth when investors withdraw money from their portfolio over time. This contradicts the common belief that earning a higher rate of return should be the goal of every investor.

To illustrate the impact of portfolio volatility, assume a physician retires with a $5,000,000 investment portfolio and needs to withdraw $250,000 at the beginning of each year to cover living expenses – this withdrawal increases by 3 percent each year to keep up with inflation. Also assume the physician can choose from two hypothetical portfolios to invest into for the next 20 years – Portfolio A will achieve an annualized return of 6.75 percent and Portfolio B will achieve 5.75 percent.

Now stop for a moment and ask yourself – if, in advance of retirement, you knew that it would be possible to earn 1 percent more per year for the next 20 years by merely selecting one portfolio over another, which one would you choose, Portfolio A or Portfolio B? Do you think $5,000,000 is enough for the physician to live on in retirement? Review the tables below to see the results of your choice.

Portfolio A provided a 6.75 percent annualized rate of return and withdrawals totaling $5,844,515. However the account was depleted after 18 years. Portfolio B – despite achieving a lower annualized return of 5.75 percent, produced $6,717,594 in withdrawals. Comparatively, Portfolio B produced nearly $1,000,000 more in retirement income and ended the 20 year period with $1,709,305!

So, why the huge disparity in results? There’s one answer – volatility. Portfolio A had a standard deviation of 16.80 percent and Portfolio B, a standard deviation of 9.39 percent. Standard Deviation is the statistic commonly used to measure volatility. Think of it this way: “Standard” = typical; “Deviation” = variance. So, “Standard Deviation” is the measure of how much an investment typically varies from its historical average return. All investments have volatility, though levels differ. So while Portfolio A had a marginally higher return than Portfolio B, it was nearly twice as volatile.

<table>
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<th>Retirement Year</th>
<th>Beginning of Year Balance</th>
<th>Withdrawal Amount</th>
<th>Balance for Growth</th>
<th>12 Month Return</th>
<th>End of Year Balance</th>
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Total Withdrawals $5,844,515 Ending Value $0.00

Standard Deviation 16.80%

This series of 12 month returns was constructed to produce a 6.75% annualized return and a 16.80% standard deviation, which can be characteristic of an all stock portfolio.

Don’t Let Portfolio Volatility Drain Your Wealth

By Nathan Mersereau, CFP, AAMS
Investment assets must be sold in order to take distributions from a portfolio. If the portfolio experiences wide swings in value (high volatility), it increases the probability that shares will need to be sold at an inopportune time – such as during a market decline. During such declines, more shares would need to be sold in order to raise the desired cash to cover living expenses. This effect is what is called “volatility drain,” when capital is depleted faster during steep market declines.

Too often, investors chase high returning portfolios hoping their accumulated assets will last longer in retirement, but in pursuing a higher rate of return, they inadvertently experience more volatility than expected. It is important to mitigate the effects of portfolio volatility, which, as illustrated above, can be detrimental to the portfolio’s longevity.

To avoid this mistake, be sure your investment portfolio is designed to target a specific level of volatility. The level should be based on your objectives, accumulated assets, sources of fixed income, time horizon and tolerance for volatility. When it comes time to withdraw cash from your portfolio, consider taking withdrawals from stable assets and opportunistically replenish that asset base when conditions are favorable. Stable assets, like bonds, typically have experienced lower volatility than growth assets, like stocks. Having a stable asset base in place for your withdrawal needs allows growth assets to endure periods of high volatility. This structure allows you to meet income needs without hampering future growth opportunities.

Want to avoid common investing mistakes? Request a copy of our newly released whitepaper Eight Mistakes Physicians Make with Their Money and How to Avoid Them by contacting co-author Joe Olekszyk at 888-958-1990 or downloading a copy from our website www.wealthcareadvisors.com.
The Affordable Care Act (ACA) requires that plans have certain benefits in order to be considered a qualified health plan (QHP). For groups to be compliant with health care reform regulation in 2014, they must meet the following mandated benefits requirements:

**Essential Health Benefits**
Beginning in 2014, all non-grandfathered health plans in the individual and small group markets (both inside and outside the Exchange) will be required to cover ten categories of Essential Health Benefits (EHBs). Therefore, if you are a small employer, you will still need to ensure that your plan has EHBs.

Each state was required to choose an EHB benchmark plan. Michigan has recommended the Priority Health HMO plan as the benchmark plan. Once approved by the federal government, all other carriers will have to mirror this benchmark plan’s EHBs.

**Metal Levels**
On January 1, 2014, all non-grandfathered plans in the individual and small group markets (both inside and outside the Exchange) must have coverage that meets certain levels of coverage, based on an actuarial value. They are called metal levels since they are referred to as the bronze, silver, gold and platinum plans.

The actuarial value is the percent that the carrier will cover for essential health benefits. For example, for the Gold plan, the carrier will on average pay 80 percent of the costs for essential health benefits while the covered individual pays 20 percent through a combination of coinsurance, copayments, and/or deductibles. The premium is not used to calculate the actuarial values.

The metal levels are defined by a target actuarial value (AV) that a qualified health plan must achieve. However, the AV can be within two percent of the target. The graph to the right shows the AV range for each metal level. There are catastrophic plans available for the individual market.

There are several things to note about the metal levels:

- Plans cannot exist between the levels. For example, a plan with an AV of 86 percent will not be considered a qualified health plan.
- If an employer is funding a HRA or HSA, there is still some question on whether the contribution amount needs to be considered to determine the AV. This could mean that the health insurance carriers will dictate the employer contribution to a HRA or HSA.
- Catastrophic plans are only available in the individual market for young adults (i.e., under 30) or to mandate-exempt individuals due to hardship or affordability
- Carriers must offer at least one Silver and one Gold product to participate in the Marketplace.

**Cost Sharing Requirement**
The ACA requires that all cost-sharing elements be applied to the out-of-pocket maximum (OOP) accumulator. Currently, most copayments (flat dollar amounts) are not used to accumulate towards the OOP maximum. With this new requirement, coinsurance and copayments for medical and drug benefits will be combined to calculate the OOP maximum. If a plan has multiple service providers, such as separate administrators for medical and pharmacy coverage, there are special transition rules since it may be difficult to comply with this requirement by 2014.

As the health insurance carriers determine how their current plan offerings may need to change to comply with these above requirements, they will inform the agent community. The anticipated timeframe on this information will be early summer. 

*Please note the effective date for all of these requirements is 1/1/2014. If you have a renewal after 1/1/2014, you will not have to make a change until your renewal date.*
Cleared for Take-Off

By Cindy Ackerman

The Michigan State Medical Society Alliance has launched another year. In April, the Alliance concluded its 87th Annual Session at the Amway Grand Plaza Hotel. In addition to the “usual” business, we approved a significant revision of our bylaws and made dramatic cuts to our budget. We also enjoyed getting together with old and new Alliance friends and had a great time at the Presidential Banquet honoring Doctor Ken Elmassian.

The MSMSA is a partner organization of MSMS the same way our members are partners and spouses of physicians. Some of our members are even physicians themselves. Working in partnership with MSMS to improve public health is a large part of our mission. We sit on MSMS committees. We advocate for physician and patient-friendly legislation. We provide support for the medical family. The Alliance exists to amplify physicians’ voices and to help promote health care and the future of medicine in Michigan.

The Alliance has been busy reorganizing this past year. We are transitioning from MSMS’s Association Management firm to Wayne County Medical Society of Southeast Michigan for our administrative services. We have recruited a new graphic designer for our newsletter, Alliance in Action. We also have a brand new website: www.msmsa.org. Both the graphic designer and the webmaster are donating their time and talents. In addition, the Alliance has an energetic Board of Directors that will see to it that these changes, and the others sure to come, position the Alliance to be leaner yet stronger.

Now that our reorganization is nearly complete, I would like to focus on the year ahead. The MSMS Board has identified childhood obesity as one of five “high priority” issues in Michigan. The Alliance, also passionate about curbing childhood obesity, hopes to find a way to work alongside MSMS on this critical public health issue.

In September, Alliance leaders will spend a day at the State Capitol experiencing the legislative process and promoting the MSMS Legislative Agenda. The Alliance has always advocated for health and medical issues and we intend be equally committed going forward.

MSMSA and MSMS have a long history of serving as a united voice for the family of medicine. We encourage MSMS to share the Alliance with your colleagues, families and friends.
Since it was first licensed in the 1950s, the annual seasonal influenza vaccine has been an inactivated influenza vaccine, trivalent (IIV3) composed of 3 influenza viral antigens – 2 influenza A antigens and 1 influenza B antigen. In 2003, the first live attenuated influenza vaccine was licensed. In recent years, vaccine manufacturers and researchers have focused on developing improved influenza vaccines which has resulted in:

- A high dose influenza vaccine with 4 times the virus antigen to create a stronger immune response in persons 65 and older (licensed for 2010-11 influenza season).
- An intradermal influenza vaccine with a very fine needle that is 90 percent smaller than the needles used for regular flu shots (licensed for 2011-12 influenza season).
- A recombinant influenza vaccine made with insect viruses using egg free production methods (licensed for 2013-14 influenza season).
- Quadrivalent influenza vaccines which protect against two influenza A strains and 2 influenza B strains (licensed for 2013-14 influenza season).

These advancements illustrate the exciting progress in influenza vaccine technology; however, having multiple brands and age indications makes it vital for providers to pay close attention when purchasing and administering flu vaccine in the upcoming season.

As the 2013-14 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. Below are the approved types/brands of flu vaccine as of April 2013.

### Vaccine Type

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Brand Name</th>
<th>Age Indication</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trivalent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IIV3</td>
<td><em>Fluzone</em></td>
<td>6 months &amp; older</td>
<td>sanofi pasteur</td>
</tr>
<tr>
<td>IIV3</td>
<td><em>Fluarix</em></td>
<td>3 months &amp; older</td>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td>IIV3</td>
<td>Fluvirin™</td>
<td>3 years &amp; older</td>
<td>Novartis</td>
</tr>
<tr>
<td>IIV3</td>
<td>Afluria®</td>
<td>4 years &amp; older</td>
<td>CSL Biotherapies</td>
</tr>
<tr>
<td>IIV3</td>
<td>FluLaval™</td>
<td>9 years &amp; older</td>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td>IIV3 ID</td>
<td>FluZone Intradermal®</td>
<td>18 through 64 years</td>
<td>sanofi pasteur</td>
</tr>
<tr>
<td>IIV3 High Dose</td>
<td>Fluzone High Dose®</td>
<td>65 years &amp; older</td>
<td>Novartis</td>
</tr>
<tr>
<td>HcIV3</td>
<td>Flucelvax®</td>
<td>18 years &amp; older</td>
<td>Protein Sciences</td>
</tr>
<tr>
<td>RIV3</td>
<td>Flublok®</td>
<td>18 through 49 years</td>
<td></td>
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<tr>
<td><strong>Quadrivalent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IIV4</td>
<td>*Fluarix Quadrivalent®</td>
<td>3 years &amp; older</td>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td>IIV4</td>
<td>*FluMist Quadrivalent®</td>
<td>2 through 49 years</td>
<td>MedImmune</td>
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<td>LAIV4</td>
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</tbody>
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The Michigan Care Improvement Registry Turns 16

MCIR is turning 16 years old this year! This is a good time to take a closer look at MCIR, and consider how it started, and how it has evolved to become such a critical part of providing immunizations in the State of Michigan today.

The Michigan Childhood Immunization Registry (MCIR), as it was originally named, was created in 1997 as a strategy to increase the immunization levels of children in Michigan. The goal was to provide a reliable, easily accessible software tool which consolidates immunization records for children for the entire state.

From the beginning, MCIR was designed to be marketed and implemented to local communities while providing access to all immunization providers, both public and private, anywhere in the state. MCIR is populated using birth data submitted from the state’s electronic birth certificate system, which originates in the birthing hospital. MCIR records are updated with health information including immunization records submitted by physicians and
other health care providers. While MCIR is a single database accessible through a secure web page, there are six regions across the state that are responsible for communicating with providers, providing technical assistance and developing procedures and protocols through their own governance boards. This decentralized approach has helped establish local ownership with a more receptive buy-in from public and private providers. The registry has been welcomed by health care professionals who recognize the value of having immunization records in a single location, no matter where a child receives vaccines.

MCIR’s numerous benefits include:

- Providing assessments and printouts of a child’s immunization record, as well as due dates for the next recommended vaccines
- Assisting managed care organizations with The Health Plan Employer Data and Information Set (HEDIS) reporting
- Generating recall notices to the parents or guardians of children who are past due for recommended immunizations

In addition, the MCIR vaccine inventory module (VIM) assists providers in managing vaccine inventory, thus increasing efficiency in providers’ offices. In 2006, the Michigan Public Health Code was modified to allow MCIR to collect immunization information on individuals of any age. Since it was becoming a lifespan registry, its name was changed to the Michigan Care Improvement Registry, retaining the MCIR acronym. Another important change to the Public Health Code was that it allowed MCIR to interoperate with other public health data. Since MCIR has over 30,000 users, making additional public health data available to better manage patient care is critical to improving health care in Michigan.

Since that time, MCIR has undergone many changes, and it now provides benefits that weren’t even thought of 16 years ago. MCIR has integrated lead, early hearing and detection intervention (EHDI), newborn screening (NBS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) results for providers to access, and has recently implemented Body Mass Index (BMI) clinical decision support for providers in Michigan. In addition, sickle cell case reporting is managed through MCIR.

MCIR has also been enhanced so it has the ability to track vaccines and biologics to be used in an emergency situation. In a public health emergency such as pandemic influenza, the MCIR All Hazards module serves a useful role in tracking persons vaccinated and/or provided prophylaxis as a result of an emergency.

The purpose of MCIR is not merely to be a warehouse for immunization records. Rather, the ultimate goal is that MCIR can be a tool used to assure that all individuals are vaccinated on time. We wish to thank Michigan physicians and health care providers for your role in making MCIR an integral part of providing immunizations in our state. Our registry wouldn’t be a nationally-recognized success without your continued commitment to using MCIR in your practices to improve health care for Michigan families.
Michigan Conference on CME Accreditation
Date: Thursday, August 8, 2013
Time: 8:00 a.m. to 4:00 p.m.
Location: Bavarian Inn Lodge, Frankenmuth
Contact: Marcie Barnum, (517) 336-5724 or mbarnum@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians CME Leaders (Directors and CME Committee members), educators, coordinators and CME administrative staff members

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

17th Annual Conference of Bioethics
Date: Friday and Saturday, September 27 & 28, 2013
Time: Friday, 5:30-8:00 p.m.
Saturday, 8:00 a.m. to 5:00 p.m.
Location: The Campus Inn, Ann Arbor
Contact: Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org
Note: Dinner on Friday, continental breakfast and lunch on Saturday will be provided.
Intended for: Physicians, bioethicists, residents, students, other health care professionals and all individuals interested in bioethical issues

NEW! – MSMS Medical Coding and Billing Summit
Date: Wednesday and Thursday, October 2 & 3, 2013
Location: Weber’s Inn, Ann Arbor
Contact: Kate McPherson, (517) 336-5755 or kmcpherson@msms.org
Intended for: Physicians, coders, billers, office administrators/managers, and all other office staff.

MSMS Physician Executive Development Program
Date: Wednesday, October 9
Time: 8:45 a.m. to 5:00 p.m.
Date: Wednesday, November 6
Time: 8:45 a.m. to 5:00 p.m.
Location: Management Education Center, Troy
Two Webinars on Management Skills
Date: Monday, October 14, 2013
Time: 7:00 to 8:00 p.m.
Date: Wednesday, October 30, 2013
Time: 7:00 to 8:00 p.m.
Contact: Caryl Markzon (517) 336-7575 or cmarkzon@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians.

The Patient Centered Medical Home: Coordinated Care, Optimal Outcomes
Date: Tuesday, October 22, 2013
Time: 9:00 a.m. to 3:30 p.m.
Location: Somerset Inn, Troy
Featuring Paul Grundy, MD, PMH, Global Director of IBM Healthcare Transformation
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.

148th Annual Scientific Meeting
Date: Wednesday through Sunday, October 23 – 26, 2013
Time: 1:00 p.m. to 4:15 p.m.
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.

The Masters Series: Payer Incentives
Date: Thursday, October 24
Time: 1:30-5:00 p.m.
Location: Somerset Inn, Troy
Contact: Marcie Barnum, (517) 336-5724 or mbarnum@msms.org
Intended for: Physicians, executives, office administrators/managers, and all other health care professionals

Welcome to These New MSMS Members
Douglas Richard Bacon, MD, MA, Farmington Hills
Joshua Robert Berris, DO, Farmington Hills
Nagaraju Choragudi, MD, Iron Mountain
Megan Marie Edison, MD, Wyoming
Ladonna L. Fraser, MD, Grand Blanc
Jennifer Lelia Jenks, MD, Ann Arbor
Kristina Natalia Karanec, DO, Grand Rapids
Sandeep Henachandran Krishnan, MD, Troy
Jill Marie Paveglio, MD, Saginaw
Mohammed Radmard, MD, Bloomfield Hills
Paula Rudoni, MD, Grand Blanc
Osama M. Sheth, MD, Ann Arbor
William Benjamin Workman, DO, Mount Clemens
The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Community Health Bureau of Health Professions.

### Report Dated: 2-11-2013 through 2-15-2013

Anthony Jungho Choe, MD
Chelsea, MI

**Report:**
- Substance Abuse
- Failure to report/Comply
- Lack of Good Moral Character

### Report Dated: 2-18-2013 through 2-22-2013

Salah Elden Fathy abass, MD
Ann Arbor, MI

**Report:**
- Violation of General Duty/Negligence
  - 2-18-2013 through 2-22-2013
- Lack of Good Moral Character
  - 2-18-2013 through 2-22-2013
- Diversion, Mental/Physical
  - 2-18-2013 through 2-22-2013

### Report Dated: 3-4-2013 through 3-8-2013

Edward L. Harwell, MD
Cadillac, MI

**Report:**
- Substance Abuse
  - 3-4-2013 through 3-8-2013
- Failure to report/Comply
  - 3-4-2013 through 3-8-2013
- Lack of Good Moral Character
  - 3-4-2013 through 3-8-2013
- Drug Diversion, Mental/Physical
  - 3-4-2013 through 3-8-2013

### Report Dated: 3-18-2013 through 3-22-2013

Charles Ray Alderdice, DO
Southfield, MI

**Report:**
- Lack of Good Moral Character
  - 3-18-2013 through 3-22-2013
- Mental/Physical
  - 3-18-2013 through 3-22-2013

### Report Dated: 3-25-2013 through 3-29-2013

Rano Solidum Bofil, MD
Man, WV

**Report:**
- Substance Abuse
  - 3-25-2013 through 3-29-2013
- Failure to report/Comply
  - 3-25-2013 through 3-29-2013
- Lack of Good Moral Character
  - 3-25-2013 through 3-29-2013

### Report Dated: 3-26-2013 through 3-30-2013

Scott Andrew Graves, MD
Mount Morris, MI

**Report:**
- Substance Abuse
  - 3-26-2013 through 3-30-2013
- Failure to report/Comply
  - 3-26-2013 through 3-30-2013
- Lack of Good Moral Character
  - 3-26-2013 through 3-30-2013

### Report Dated: 4-13-2013 through 4-23-2013

Mervyn Winston Smith, MD
Grand Rapids, MI

**Report:**
- Substance Abuse
  - 4-13-2013 through 4-23-2013
- Failure to report/Comply
  - 4-13-2013 through 4-23-2013
- Lack of Good Moral Character
  - 4-13-2013 through 4-23-2013

### Report Dated: 4-1-2013 through 4-30-2013

Joseph Gluski, MD
Battle Creek, MI

**Report:**
- Substance Abuse
  - 4-1-2013 through 4-30-2013
- Failure to report/Comply
  - 4-1-2013 through 4-30-2013
- Lack of Good Moral Character
  - 4-1-2013 through 4-30-2013

### Report Dated: 4-4-2013 through 4-12-2013

Charles Ray Alderdice, MD
Saint Joseph, MI

**Report:**
- Substance Abuse
  - 4-4-2013 through 4-12-2013
- Failure to report/Comply
  - 4-4-2013 through 4-12-2013
- Lack of Good Moral Character
  - 4-4-2013 through 4-12-2013

### Report Dated: 4-15-2013 through 4-19-2013

Ari Salim Malkki, MD
Dearborn, MI

**Report:**
- Substance Abuse
  - 4-15-2013 through 4-19-2013
- Failure to report/Comply
  - 4-15-2013 through 4-19-2013
- Lack of Good Moral Character
  - 4-15-2013 through 4-19-2013

### Report Dated: 4-22-2013 through 4-26-2013

Aman U. Upadhyay, MD
Detroit, MI

**Report:**
- Substance Abuse
  - 4-22-2013 through 4-26-2013
- Failure to report/Comply
  - 4-22-2013 through 4-26-2013
- Lack of Good Moral Character
  - 4-22-2013 through 4-26-2013

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

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

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

**Summary Suspension Dissolved** – the summary suspension has been removed after an administrative review and the licensee is either allowed to practice or is subject to other disciplinary actions imposed by the Board.
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Equal Opportunity Employer
As my friends will tell you, I've never been a person to mince words or pull punches when it comes to important issues, but as the new president of the Michigan State Medical Society, I understand that I now speak for 15,000 of my physician colleagues. With that in mind, I don’t think it would be out of line for me to say that there are many individuals and special interest groups in this state who see our changing health care system as nothing more than an opportunity to advance their own causes at the expense of patient safety.

It’s troubling enough that the actions of these opportunists lead to inefficiencies, increased costs, frivolous lawsuits, and delays in care, but when they are a direct threat to the lives of my patients and their families, it’s very difficult for me to “remain calm and carry on.”

Michigan Senate Bill 2, sponsored by Sen. Mark Jansen (R-Grand Rapids), would allow advanced practice nurses to diagnose, treat, and write potentially dangerous prescriptions for patients, all without adequate training and without even collaborating with a physician. This bill scares me, and it should scare you too, because not only does it threaten to further fragment a health care system at a time when massive efforts are underway to coordinate care within patient centered medical homes and other organized systems of care, but it also puts patients at serious risk.

Patients put their lives in the hands of their health care providers every day; and physicians, nurses, technologists, and others work hard to keep that trust. We keep that trust by being transparent. We keep it by working as a team, with oversight and accountability. We keep it by doing what is right, despite the pressures put upon us. But more than anything, we keep it by putting patients first.

There’s no question that our health care system is changing, or that it needs to change. However, those changes must not be made for the sake of advancing somebody’s political agenda. If changes are to be made in our health care system, they must be made for one purpose only: to improve the health of our patients. And lowering the standards for our health care providers absolutely does not achieve that.

When it comes to improving health care, physicians know we must take the lead to ensure the health and safety of our patients – whether it’s around the world, across the country, or right here at home. When the physicians of MSMS advocate for change, you can be sure that patient safety is always at the forefront.

Some of you may know that in addition to being a physician, I am also a licensed pilot. Much like becoming a physician, I became a pilot through proper training and testing. I did not become qualified to fly an aircraft simply because the legislature said I could. And I am sure that my passengers are relieved to hear that.

I know all too well that being a physician is a demanding profession, one that continually pulls at us from many different directions. It certainly would be easier just to focus on things that are directly in front of us. We can be diligent about providing the best possible care to our patients when we treat them in our offices and feel satisfied that we’re doing our job. However, patient safety does not begin or end at our practice doors. Every physician has a duty to protect patients both inside and outside our practices.

Get to know your lawmakers. Build relationships with them. Make yourself the voice of reason when special interest groups muddy the waters. Help them understand that the health care system they are changing is the one that will treat them, their children, their friends, and their neighbors. Most importantly, demonstrate to them that physicians have always been a patient’s best advocate.

Now, keep calm and carry on....
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