MSMS Membership – How Prepared Would You Be Without It?

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• Physicians and Health Plans Prepare for Health Care’s Brave New World
• After Big Wins on Election Night, What Do We Do Now?
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Deconstructing MSMS Membership
By Stacy Sellek
If you think it’s only about the pocketbook, think again…
Think about the role MSMS plays in your profession and your practice every day – delivering resources to manage your practice, ensuring you remain at the table as health care delivery evolves, advocating for you and your patients. What’s it worth?

TREATING THE UNDERSERVED BY TRAINING THE UNDERSERVED
By Dennis Archambault
The best solution to serving medically underserved areas may be developing talent drawn from the underserved themselves.

THE EFFECT OF PAYMENT REFORM ON PHYSICIAN PRACTICES – PART 2
Physicians and Health Plans Prepare for Health Care’s Brave New World
Contributors: Stacey Hettiger, Paul Natinsky and Joe Neller
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QUESTION:
The Fourth US Circuit Court of Appeals will soon hear an appeal of a Federal Trade Commission (FTC) ruling that the North Carolina Dental Board violated antitrust laws when it sought to enforce North Carolina law against non-licensed providers of teeth whitening products and services. It seems to me this is the type of activity a state dental or medical board should be engaged in. If the Court of Appeals upholds the FTC decision, will it mean that the authority of Michigan’s and other states’ dental and medical boards to regulate their profession against individuals who are not properly licensed will be illegal?

ANSWER:
Because of the significant difference between Michigan law and North Carolina law, I do not believe a Court of Appeal’s decision upholding the FTC Ruling in North Carolina will have a negative effect here. First, let’s review what happened in North Carolina.

In 2006, the North Carolina Board of Dental Examiners began sending letters to non-dentist providers of teeth whitening products and services directing them to cease and desist from providing these products and services. Letters were also sent to mall owners/operators that allowed teeth whitening products and services to be sold at mall kiosks. These letters warned they were facilitating the illegal practice of dentistry and they themselves may be liable.

On December 2, 2011, the FTC ordered the North Carolina Board of Dentistry to stop all its efforts to prevent non-dentists from providing “teeth whitening goods” and “teeth whitening services.” The FTC ruled that the exemption from the antitrust laws applicable to state agencies that are actively supervised by the state did not apply. North Carolina appealed this FTC ruling and the Fourth US Circuit Court of Appeals is expected to issue a ruling soon.

The primary basis for the FTC’s ruling was that there was no statutory authority under North Carolina law for the cease and desist letters. Instead, the FTC believed that the North Carolina Dental Board should have instead exercised the authority it does have under North Carolina law to “bring an action to enjoin the practice in North Carolina Superior Court” or to “refer the matter to the district attorney for criminal prosecution.” Also discussed in the FTC’s opinion was the fact that no actual harm to the public was demonstrated resulting from patients using teeth whitening products and services obtained from non-licensed persons and therefore the actions of the North Carolina Dental Board served only to restrict competition in the market for these “highly sought” dental services.

This is a significant difference between the law of North Carolina and Michigan. As a result of the efforts of MSMS, the Michigan Dental Association, the Michigan Osteopathic Association and others, Michigan House Bill 5614 became law in 2010. This law specifically grants Michigan’s Boards regulating the health professions (e.g., medicine, dentistry, etc.) authority to order non-licensed persons to cease and desist from providing those services that are within the scope of the practice of a health profession. This is not the case in North Carolina.

Because the Michigan Board of Medicine has the specific statutory authority that the North Carolina Dental Board lacked, in my opinion a similar case arising in Michigan would be decided much differently by the FTC, if it were brought at all.

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 jsielski@msms.org.
Medicare Learning Network® (MLN) News about (EHR) Incentive Programs

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When I speak with my physician colleagues, I see a great deal of concern in their faces and hear the strain of change in their voices. Medical practice is under many forces of change. We are moving from sporadic care encounters to systematic care to deliver excellence. That change is both daunting and frustrating. What encouragement can we offer to our colleagues? Simply put, the key to maintaining our strength and leadership in health care is operating as physician organizations. Michigan, today, stands on the shoulders of the many visionary physicians in this state. This next phase of medicine will be led by physician organizations that continue to strategically shape how care is delivered here.

Today’s change in medicine appears to fit patterns of the past. A radical change swept through health care in the 1970s with the introduction of Health Maintenance Organizations. Similarly, sweeping change is impacting today’s care delivery. These changes require medical practices to achieve and report quality care goals. Efforts like the Patient Centered Medical Home, Accountable Care Organizations and Meaningful Use have built physician performance analysis and reporting into their core structure. Michigan's physician representation in these programs is strong and has been so from the start. These leaders understand that excellence in design must precede product.

In the near future, the practice of medicine will likely require achievement standards for marketing, insurance credentialing, facility privileges and ultimately payment. Strategic partnerships will allow high achievers to complete ranking above standard practices. Preferred provider arrangements and tiered payment models will likely follow. Several employers across the United States have used this new model to demonstrate quality control efficiencies for their employees’ health. Well-designed physician organizations demonstrate the same efficiencies traditionally in use by manufacturing to promote high quality health care.

Physician organizations offer members a competitive edge in this changing landscape. They allow members to share best practices, education, payer bargaining and administrative resources. Several such organizations have offered combined purchasing power for supplies, equipment and technology. Benefits may also include practice consulting, staff training and health information exchange.

External factors are influencing the economics of health care. A systematic care approach has been a financial buffer for our practice. Our staff thoroughly engages patients in managing their own care. When patients are reluctant to return for chronic disease appointments, my employees encourage them to return for scheduled care visits. This helps prevent increased out-of-pocket expenses and higher premiums, which can decrease volume. Our patients now boast of their care accomplishments for ‘good grades’ in place of prior grumbling about co-payment and prescription expense.

Most importantly, the physicians and other health care providers in my practice are offering their greatest degree of satisfaction in years. We have returned to connecting with individuals at visits. Our staff is screening and completing needed care interventions and we are no longer burdened with administrative responsibilities in the encounters. The practice team is collectively reinforcing that Michigan is a great place to practice medicine.

How, then, do we move forward in keeping Michigan competitive? It is important to stay informed, through meetings with respective organizations, to stay current through articles like this Michigan Medicine series on payment reform and physician organizations, and the educational offerings through MSMS and your specialty. It remains vitally important to identify leaders who will tenaciously negotiate for physicians and physician organizations. We will need change to happen from within our profession rather than to our profession. MM

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Stressed Out During the Holidays? Try These Tips to Avoid Burnout

Contributed by The Doctors Company

Stress and fatigue caused by working longer hours and inadequate staffing levels can put physicians at risk of burnout and can raise the risk of negative patient outcomes. During the holiday season, physicians may face added stress as employees, as colleagues have more personal commitments and practices may be short staffed.

The rate of physician burnout is significant. A recent study by the Mayo Clinic found that nearly half the doctors in the United States have at least one symptom of burnout.¹ According to the study, being asked to see more patients, having less time with each patient, and short patient release timelines are major stressors for physicians. Physician burnout can decrease quality of care, increase risk of errors, push physicians into early retirement, and cause problems in physicians' personal lives.

In 2010, The Doctors Company began tracking human factors as risk management issues and evaluated the influence of human factors in 862 closed liability cases. Of those cases, 114 (13 percent) included at least one human factor issue. Within those 114 cases, 14 percent dealt with conditions affecting the health care professional, including fatigue, physical or mental impairment, distractions, multitasking, or interruptions.

Stress management skills are not traditionally part of medical school curriculum. Most health care professionals are taught to put their heads down and persevere. At a time when medical professionals are increasingly in demand, as millions of patients become newly insured, practices should consider steps to prevent physician burnout and stress.

Consider these tips to help reduce stress, especially around high-stress times such as the holidays:

- Monitor staff schedules and curtail hours as needed to prevent undue fatigue.
- Call in additional physicians and staff to combat fatigue and stress.
- Provide an environment that supports staff members so that they feel comfortable expressing concerns about their stress level and ability to function effectively.
- Allow staff members to express concerns to each other if they identify signs of fatigue or stress in their colleagues.
- Encourage all staff members to take 20-minute meal breaks and get fresh air to clear their minds at least once per shift.
- Have regular one-on-one and group meetings with staff to learn their thoughts on how to make things run more smoothly.
- Encourage physicians and staff to put their focus on things they can change, not things they have no control over.

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For more patient safety articles and practice tips, or to read more about the 2010 human risk factors evaluation, visit www.thedoctors.com/patientsafety.

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References

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Deconstructing MSMS Membership

If You Think It’s Only About the Pocketbook, Think Again…

By Stacy Sellek


What synonyms would YOU use to describe the Michigan State Medical Society?

Think about the role MSMS plays in your profession and your practice every day – delivering resources to manage your practice, ensuring you remain at the table as health care delivery evolves, and advocating for you and your patients.

What’s It Worth?

There’s no doubt it’s a tough economy, and everyone is feeling its effects in some way. But make no mistake: MSMS is one of the soundest investments you can make in your profession, your livelihood.

“The health care environment is ever-changing, and physicians today face unprecedented challenges and unprecedented opportunities,” said MSMS President John G. Bizon, MD. “MSMS has a plan, and is here to help you meet those challenges, and seize those opportunities confidently armed with information, tools and expertise.”

Contemplating Our Navel

What makes a professional association effective? There is no simple answer to that question, because there are so many important things that associations do for their members. But whatever you think a professional membership organization is or should be, MSMS distinguishes itself by delivering superior services and resources, and continually exceeding the expectations of its 16,000+ physician members every year.

Breaking down what makes MSMS work, we offer this – the anatomy of an effective organization:

THE HEAD – This is our leadership – our Board of Directors, Officers, House of Delegates, and Executive Director, which collectively represent direction and vision. Prime examples: MSMS Future of Medicine Strategic Plan (www.msms.org/future); MSMS House of Delegates; MSMS committees and task forces. It is through these channels that MSMS educational programming, legislative advocacy, efforts to keep physicians at the table with third party payers and regulatory agencies, and efforts to improve the public health of our state take shape.
"The conversation around the board table at MSMS, and among physicians across the state, is about keeping the focus on essential areas, even amid the noise and uncertainty in health care today," said MSMS Board Chair James D. Grant, MD. "It would be easy to get distracted by each new challenge or old problem that raises its ugly head. So, we are zeroing in on those things that matter most – those things that will move us in the right direction."

THE HEART – Our members – YOU – are the lifeblood and the core of this organization. Without your participation and your support, MSMS could not exist. We need all members – practicing physicians, academic physicians, physician executives, retired physicians, residents, students – to be engaged on many levels for MSMS to thrive. If you haven’t done so already, please renew your membership today (www.msms.org/renew). If you have already renewed, we thank you for belonging!

THE BONES – The services and resources we provide to members represent our internal framework. Also, our subsidiaries and affiliates give us the structure and support to deliver valuable – and invaluable – products and services, such as educational programming, reimbursement and coding assistance, insurance products, practice management assistance, and legal information.

THE MUSCLE – Whether they are lobbying at the state Capitol or organizing meetings, the staff at MSMS put things in motion for members. Throughout the year, they work both out in front and behind the scenes to execute policies, support committees, advocate on physicians’ behalf, and make sure members are well informed.

The Tangibles
Your membership investment yields returns time after time as MSMS performs services and produces resources that matter to your practice every day, whether you know it or not. Starting with red tape, you can count on MSMS Reimbursement Advocate Stacie Saylor, CPC, to unstick claims and get you paid for your services. Stacie’s years of experience and expertise combined with her connections to major payers in Michigan are priceless, and they are free to MSMS members.

You might be sick of hearing about “meaningful use of health information technology” (HIT), but the federal government has made it a fact of life in medical practice. MSMS helps your practice get up to speed on adopting and using HIT through tools such as HIT Alerts, educational courses, and a dedicated web page that serves as your one-stop-shop for all things HIT. In addition, meaningful use experts at MSMS will even come to your office to guide you and your staff through the process if you need more in-depth assistance.

When you are ready to start using your smartphone or tablet to communicate with patients, as more and more physicians are doing, MSMS offers a free HIPAA-compliant mobile application to members called DocBookMD. Doctors in 22 other states have been using DocBookMD to view EKGs, review X-rays, access pharmacy directories, and more. DocBookMD speeds communication, improves workflow, and ultimately can lower the cost of health care.

Something else that’s worth the price of admission: access to insurance products just for you, your employees and your family – and partnered businesses to help manage your practice. Who better to insure physicians than an insurance agency that specializes in insuring physicians? The MSMS Physicians Insurance Agency offers a full range of great coverage at competitive rates and superior value like no other company can. When you need to find outside vendors to assist your practice, the MSMS Practice Partner program connects you with reputable businesses that we vet and contract to give members exclusive services and benefits.

In addition to the tools and resources above, MSMS offers a wide array of other benefits exclusive to members, such as a library of free Legal Alerts, legal consulting services and guides, Starting or Joining Practice Handbook, and much more. Put these resources to work for you today.

Lead, Follow or Get Out of the Way...
Whether you agree with the Affordable Care Act (ACA) or not, it undoubtedly has prompted new health care delivery models (accountable care organizations, patient centered medical home) and new payer roles that necessitate physician engagement at the top. As a result, physicians now have more opportunities to

"As a physician, I would like to extend my thanks to MSMS for what you are doing on our behalf. Keep up the good job."
—Marianna V. Spanaki-Varelas, MD, an Oakland County neurologist, on how MSMS prepared her to testify in Lansing on impaired driver bills

"The Michigan State Medical Society Annual Meeting was especially rewarding for me. What I really enjoy is the opportunity to discuss new ideas and develop new solutions to problems."
—Michael Oleyar, former Michigan State University College of Osteopathic Medicine student, after experiencing the 2010 MSMS House of Delegates meeting

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—Michael Oleyar, former Michigan State University College of Osteopathic Medicine student, after experiencing the 2010 MSMS House of Delegates meeting

"Without [MSMS], there’s a good possibility that I wouldn’t find out a lot of things I need to find out. I really think you’re a good organization. A physician would be foolish not to be a member."
—Wendy Cook, Office Manager, Freedom Medical Clinic, Livonia, on how membership in MSMS benefits practices

"I come to the ASM because the diversity of topics always gives me new tools and improved diagnostic skills in caring for my patients."
—Donald R. Moore, MD, a Wayne County internist, on the value of the Annual Scientific Meeting, the crown jewel of MSMS’s educational programming
step into leadership roles and develop new skills along the way. With these opportunities also comes a responsibility because if physicians don’t take charge in this capacity, someone else will. This is a chance for physicians to set the course for the future of medicine and health care in America.

Enter MSMS. With many conferences and tools aimed at fostering physician leadership, MSMS can prepare you for these challenges and help you make a difference in the changing health care environment.

The Physician Executive Development Program (www.msms.org/eo) is a prime example. Introduced earlier this year, its sole purpose is to give members the real-life insight and practical intelligence from their colleagues – actual physician leaders – who are pioneers in these new models.

“I chose the MSMS Physician Executive Development Program over similar programs sponsored by hospitals, corporations or other entities because of the opportunity to interact with experienced physician leaders from across the state and nearby communities,” remarked MSMS Board Member Cheryl Gibson Fountain, MD, who attended the winter/spring series this year. “This program gave me the opportunity to seek advice, learn from, and tap into the collective experience of seasoned professionals and physician leaders who are working in the trenches every day.”

One of those physicians in the trenches is Mary Ellen Benzik, MD, Chief Medical Officer, Health Networks, Trinity Health, who spoke at the final conference of the winter/spring series. “Leadership in change cannot be external to physicians. It must be ours; we must own it,” she emphasized. “Physicians need to connect the dots that other people don’t see. We have to know what means something and resonates to all stakeholders in health care, including community partners, employers, etc.”

Beyond executive roles, however, lie abundant leadership opportunities around you every day: to educate the public through news and social media about important issues; to engage yourself and your colleagues in health care policy through MSMS committees; and to represent your profession and your patients through legislative advocacy efforts. MSMS can help you thrive in these capacities and more.

In a nutshell: MSMS has your back. Over and over again.

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

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–Gregory J. Forzley, MD, Chair, Michigan Health Information Network

The author is Senior Manager, MSMS Communications & Public Relations.
Treating the Underserved by Training the Underserved

By Dennis Archambault

The best solution to serving medically underserved areas may be developing talent drawn from the underserved themselves. But disadvantaged students often lack the dream, as well as academic discipline, to even pursue a health career.

Many have tried to reach promising young people through mentoring programs at various stages of the education system. One program, the Area Health Education Center (AHEC), promises to link these programs and provide regional pipelines to introduce young people to the health careers.

“Connecting Students to Careers...Professionals to Communities...and Communities to Better Health” is a tall order, which needs to be approached incrementally and strategically. The Michigan AHEC, based at Wayne State University, and organized through five regions in the state, is approaching this challenge in three focus areas:

- Introduce and mentor students, kindergarten through college, regarding the possibilities in the health careers: medicine, nursing, and pharmacy, or the many support careers needed to fully staff community health centers.
- Increase clinical placements of health care career students in underserved areas.
- Provide workforce development opportunities for medical professionals in urban and rural settings, medically underserved populations, and health professional shortage areas in Michigan.

Practicing medicine in a medically underserved area was not the primary interest of Maryjean Schenk, MD, MPH, vice dean of Medical Education at the Wayne State University School of Medicine. Her experience with the National Health Service Corps in rural Virginia taught her about the need for health professionals there. “Ever since that time, I have come to appreciate the need to make students in medical school aware as well. AHEC is a vehicle that allows us to continue and expand this.”

AHEC focuses on mentoring young people from vulnerable communities because they’re more likely to remain or return to those communities as practitioners. “The decision of a practice site is a multifactorial decision,” says Doctor Schenk. “But a person raised in an underserved community is better able to relate to that community and is most likely inclined to remain there. They will have the natural ability to care for these people.” AHEC, she says, targets “candidates who have a connection with a community of need.” Wayne State, completing the second of a five-year AHEC grant, has established the Southeast and Mid-Central regional centers, with Western Michigan scheduled to begin in November 2012. The Northern Lower and Upper Peninsula regions will become operational in next two years. Each regional AHEC has its own advisory board and is expected to become self-sustaining center within six years of its establishment.

Rural and remote areas have some of the worst shortages of physicians, which is one of the justifications of establishing a medical school at Central Michigan University, explains Ernest Yoder, MD, dean of the CMU College of Medicine, which will admit its first class in August 2013. The best time to reach students to cultivate an interest in medical careers and to begin preparing them academically is in junior high school or before, he says. “You need to talk to young people about careers in medicine. They have the opportunity to prepare themselves and to interact with people in the field.”

Elementary school, he says, is a critical time to orient students to math and science, which American students are notoriously deficient in. Central Michigan has implemented the national Science, Technology, Engineering, Math (STEM) program, which provides early exposure to these subject areas by demonstrating “how much fun it is to learn these areas.” The worst thing for young students is to fear science and math, he says.
A related program, Great Exploration in Math and Science (GEMS), also administered through Central Michigan, focuses on helping to teach these subject areas at local schools, from pre-kindergarten through eighth grade. The university staffs a GEMS center on its Mt. Pleasant campus.

AHEC is as much about linking existing programs designed to promote health careers as it is creating new ones, notes Richard Long, PhD, associate dean of the Western Michigan University College of Health and Human Services. Western Michigan sponsors several science and technology programs in elementary and middle schools, and has achieved a “modest level of success” in retaining health professionals in the area, notes Long. AHEC will link Western Michigan’s programs with others in the region to foster synergy among them, he adds.

AHEC, Long says, must also help develop more allied health professionals – specifically, physician extenders, to meet the primary care needs of the state. “There’s no way all of the medical schools – even with the new schools – will meet the primary care need.” A new medical school, affiliated with Western Michigan University but operating independently of the university, will accept its first class in August 2014.

“The reason primary care jobs are so hard to fill is because they involve practice in rural areas with low population density. There’s limited access to specialty services for support. These are the kinds of primary care practices where physicians burn out; they literally work themselves to death without specialty support. Primary care physicians are looking for group practices, better reimbursement, time off. All of that doesn’t translate well in rural counties…. It’s more likely that the kids who grow up in rural areas will return and practice there. We’re trying to develop the pipeline concept. If we can develop home-grown providers, particularly those who are bilingual, we will be better off.”

Poor academic performance is a significant challenge for all students, rural or urban. Desire isn’t enough. You have to pass the standardized test, says Doctor Schenk. For that, Wayne State has developed “a robust academic enrichment program for medical students, as well as other students such as biomedical engineers.”

Even though a student may have desire and academic ability, there still is the problem of paying for the education. While speaking with potential students in the Upper Peninsula, Doctor Schenk was surprised to learn that the fear of medical school debt was strong enough to dissuade some students from even entering the pipeline: “They asked me, ‘How can I afford medical school?’ A lot of students may have the ability, but they can’t see the pathway. I tell them, ‘Once you make it into medical school, we’ll help you get over it,’ in terms of finding grants and other forms of financial support.”

Above all, AHEC needs to create a vision of possibility: that without family or community role models, despite rigorous academic challenges, and despite the enormous financial burden, a health career is a realizable dream.

“How do you create the possibility?” Doctor Long asks. “You create programs that are sustainable and touch young people over time, beginning early in their educational life. You challenge kids. Some of them have academic deficits; they’re afraid of the challenges. You have to coach them along. You bring them in, give them opportunity to think creatively, and it’s amazing to see them rise to the occasion.”

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The author is a Southeast Michigan health care writer.
The Effect of Payment Reform on Physician Practices

PART 2
Physicians and Health Plans Prepare for Health Care’s Brave New World

Contributors: Stacey Hettiger, Paul Natinsky and Joe Neller

In our last installment, we wrote globally about the nature and permanence of trends in physician payment models, particularly the shift from fee-for-service to fee-for-value. In our second communique, we will look specifically at major health plans with which physicians will be working and provide an overview of the payment methods, programs, and demonstrations affecting Michigan physicians and the health care delivery model.

Physicians and health plans have been charged with the mission of holding the line on health care costs (which have reached $2.6 billion annually), while providing care for an estimated 30 million newly insured patients and assuming responsibility for improving the health status of large groups of patients. With this gargantuan mission comes a tome of new rules and regulations, a drastic change in the way physicians are paid, and a convergence of new and old payment and practice systems that will come to center stage.

Leading this seismic change are the increase in the number of patients who will seek health care services as a result of Medicaid’s expansion and the individual health insurance mandate contained in the Patient Protection and Affordable Care Act (typically referred to as ACA), changes in the way payers reimburse physicians, and the host of new programs and practice paradigms to which physicians must adjust in this brave new world.

A recent report issued by the Center for Healthcare Research and Transformation reported that the number of uninsured Michigan residents is estimated to fall to 290,960 by 2020 if Michigan expands Medicaid eligibility in 2014 as permitted by ACA. This means that over 900,000 currently uninsured Michigan residents will have either private or public health insurance coverage. The report projects that over time the expansion will bring approximately 618,000 people, the majority of whom are uninsured today, into the Medicaid program.

All three of the medical directors we interviewed commented on the promise that more people will be insured. They are keenly aware that the projected influx of newly insured residents presents as many challenges as it does opportunities.

“I would say one of the most promising aspects is an opportunity to have people insured,” said Richard Frank, MD, MHSA, Vice President and Chief Medical Officer at HealthPlus of Michigan. “So when one thinks about caring for the citizens of this country, be they part of my business or not, we know for a fact that having them insured improves their general care.”

“The most challenging [aspect of health care reform] is the number of people who are going to come into the system,” said Marc Keshishian, MD, Senior Vice President and Chief Medical Officer at Blue Care Network. “We’re going to have to make sure that there are enough health care providers available – especially primary care providers – for the citizens of this state to be seen in a timely manner. We know what happened in Massachusetts, that there are long wait times for primary care physician visits. So I see that as a huge challenge.”

“How are we going to care for all of the additional people with coverage? And how are we going to deliver all of the covered services that are going to be required, such as preventive care? Clearly there is going to be a big demand for services around primary care,” said Burton F. VanderLaan, MD, Medical Director at Priority Health. “I think Michigan is actually situated better than some other states because we’ve had a lot of ground work done over the past couple of years with patient centered medical homes.”

Meeting the Challenges Head-on

Health plans and other payers are implementing practice and payment transformation initiatives in an effort to cover additional lives while improving quality of care and increasing patient and provider satisfaction in a revenue neutral environment. To date, many of these efforts have focused on a shift from the traditional fee-for-service payment structure that pays health care providers based on the number and cost of procedures they perform to “fee-for-value” reimbursement. Pay-for-performance (P4P), Patient-Centered Medical Home (PCMH), shared savings, global payments, and episode-of-care payments are the current buzzwords. Many of the fee-for-value payment structures are designed to recognize management of the health of a patient and a community of patients before (prevention), during (intervention), and after (maintenance) episodes of care.

And, in the Pathways for Physician Success Under Healthcare Payment and Delivery Reforms, Harold Miller observed that “most discussions about payment reform have focused on three basic models of payment: (1) payment changes to support patient-centered medical homes; (2) episode-of-care payments to improve the quality and reduce the cost of major acute care; and (3) comprehensive care or “global” payments to improve the quality and reduce the cost of the full range of healthcare services for a population of patients.”

“As for down the road, there is a lot of talk about bundled payments and episode-based payments, which is a possibility, but long-term I think what people are looking at are forms of
global budgets and population-based payment around global budgets,” said Doctor VanderLaan.

Paying for Value

In Michigan, some fee-for-value methodologies have been used and evolved by health plans for a number of years. The Healthcare Effectiveness Data and Information Set (HEDIS®) has been used to measure key health indicators for some time and bonus payments are often tied to successful completion of HEDIS®.

“We have a long history of rewarding physicians for providing high-quality care. We measure quality – which is very difficult to do – through the HEDIS® measures that are set forth by an independent organization,” said Doctor Keshishian.

HEDIS® measures include tracking the number/percentage of patients who properly use their asthma medication, controlling patients’ high blood pressure, and managing cases of diabetes. HEDIS®, developed and maintained by the National Committee for Quality Assurance, was originally used to compare performance among health plans. It is now also used internally by many health plans to identify areas in need of improvement and to help structure incentives for physicians and other health care providers.

Typically, bonuses are paid to primary care physicians who successfully facilitate completion of identified HEDIS® measurement domains designed to achieve desired clinical outcomes. For example, Blue Care Network’s Performance Recognition Program, HealthPlus of Michigan’s HMO Pay for Performances Program, and Priority Health’s Partners in Performance Program (PIP) all offer financial incentives for Hemoglobin A1c testing for diabetics and various preventive screenings such as breast cancer screening and lead screening in children. Depending on the measurement, incentives are reimbursed via a flat rate, per member per month (PMPM), or shared savings payment methodology and may be weighted or tiered.

According to Doctor VanderLaan, Priority Health has already moved a significant amount of its reimbursement in primary care to the PIP value-based incentive program. He added that roughly 15 percent of the primary care reimbursement that comes through PIP is based on quality outcomes.

In addition, many Michigan payers recognize and reward physicians for achieving PCMH status and/or metrics. PCMH is a care model that focuses on a physician-led team coordinating the multiple care needs of patients while also engaging patients as proactive managers of their health. It was originally conceived in the 1960s from a concept introduced by the American Academy of Pediatrics (AAP). It experienced a rebirth several years ago as a way to focus on the delivery of comprehensive and coordinated patient care. In March 2007, the AAP, the American College of Physicians, the American Academy of Family Physicians, and the American Osteopathic Association issued the “Joint Principles of the Patient-Centered Medical Home.” While there are variations in the criteria and measures different entities may use to designate the achievement of PCMH status, at this time, the Joint Principles are generally looked upon as the consensus definition.

“I would say that the marketplace is going to be changed for this efficiency, quality and member experience,” said Doctor Frank. “The key element for physicians to understand is that fee-for-service as it was constructed years ago will be replaced over time by this new emphasis on value. To the extent that physicians begin to think about the services they provide from a cost, quality and experience perspective – that’s how they can prepare for that new emphasis. Each specialty, each employment situation, and each health system will respond differently to each of those elements, but physicians, health systems, PHOs, and POs will all need to ask, ‘What is my value proposition for the marketplace? How can I improve the marketplace value to attract and gain more patients?’”

Leading the Way in Innovation

Michigan is one of eight states participating in the Centers for Medicare and Medicaid Services (CMS) Multi-Payer Advanced Primary Care (ACP) Demonstration, which uses elements of the PCMH in its mission and methodology. This is the federal demonstration project that partners Medicare with Medicaid and private insurers on initiatives around the medical home concept. Demonstration goals include improved quality and coordination of health care services, evaluation of the impact of ACP practices (or medical homes) on several factors, and implementation of a common payment method across multiple participating payers in order to reduce administrative burdens, align economic incentives, and provide necessary resources to sustain the ACP model in participating practices.

Michigan’s Primary Care Transformation (MiPCT) Demonstration Project has been operational since January 2012. There are approximately 35 physician organizations (POs) with 500 practices participating. This represents more than 1,785 physicians and 1.2 million patients. MiPCT participating plans are Blue Cross Blue Shield of Michigan (BCBSM), Blue Care Network (BCN), Medicare Fee-For-Service, and all Medicaid managed care plans. Key interventions in the first year include building PCMH infrastructure (such as extended access and patient registry functionality) and embedding care managers into participating practices.

“BCBSM and BCN are very supportive of the Michigan Primary Care Transformation, which is trying to help physicians’ offices and actually supporting them financially in order to transform primary care,” said Doctor Keshishian. “With that, we hope there will be fewer people coming in to see the doctors and chronic care will be coordinated by primary care physicians and the nurses that they hire through the Michigan Primary Care Transformation project.”

Clinical Integration Efforts and Survival Strategies

Regardless of their specific design, new payment models from commercial insurance and government payers will require physicians to make practice changes in their customary fee-for-service approach. Under new models, physicians must emphasize system delivery
efficiency – as opposed to service volume – and will rely more on other specialists or community partners’ accountability for their patients’ care. It will be difficult, if not impossible, to achieve the goals of this new environment without investments in advanced information systems that help optimize quality and enhance communication for care coordination.

The most successful future practices will adopt a robust technology infrastructure to gather the data necessary to demonstrate the high-quality, lower-cost care that will be the most profitable. Technology – such as an electronic medical record or, at a minimum, a disease registry – will allow physicians to identify patients with chronic conditions and provide them with ongoing services to manage their health and ultimately improve outcomes. Some plans have designed the new payment models to provide the support needed for practices to invest in the necessary IT tools.

In 2012, Priority Health expanded its PIP program to recognize natural alignments in the delivery of care by attributing all members to a medical home and every provider to an accountable care network. This recognition will continue in 2013. In addition, Priority Health began offering prospective payments in the form of PMPM payouts to support infrastructure improvements in patient registry data submission, care coordination, acceptance of Medicaid patients, and PCMH recognition.

“[We have an incentive program] that incents care coordination, care management, and the use of registries; all those pieces of infrastructure that are specific to integration,” said Doctor VanderLaan. “Well over 90 percent of our members at the time of enrollment select a medical home or have a medical home…. That means that most of our members are in clearly defined networks of care, and we can provide population-level care to those networks on the cost and the quality of their covered Priority lives.”

Health plans, whether they are currently participating in these programs or not, have been thinking and preparing, both short- and long-term, for the changes they see coming. And while all health plans may have varying ideas for solutions to improve payment models, most see HIT as a necessary component for system improvement.

“For the long term, I think the United States is probably going to need some flexibility in the way we deliver health care so that we can meet the needs of the additional 30 million insured folks in this country,” said Doctor Frank. “The nature of that is unclear. There are probably a number of solutions that will help. Possibilities include telemedicine, mid-level providers, team-based care, group visits, and more IT to improve productivity.”

In addition to optimizing patient care through data, practices should use technology infrastructure to connect to the community of other specialists or health care settings. As payment models move toward bundled or global payment models, it will become increasingly important that physicians coordinate their patients’ care with other specialists and hospitals that share in the accountability for the cost and quality of services. The commercial insurance and government programs implementing these payment models hope improved communication across settings will result in more appropriate utilization of resources by eliminating redundant or unnecessary services.

“The way that we’re looking in the future is bringing more care around an episodic approach,” said Doctor Frank. “For example, if one is going to manage episodes of care, how does one evaluate the number of episodes that should occur within a population? How does a plan adequately compensate a provider – be it a hospital, physician or other entity – for managing an episode, given that there is a certain amount of risk associated?”

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As a result of the emphasis on efficiency across settings and physician specialties, there has been an acceleration of market consolidation in health care with many practices linking together through a physician organization, physician hospital organization, or large health system. Much of this consolidation can be attributed to bundled or episode-based payments and the effects these models have on practice or system delivery design.

“I think it is mainly a reflection of all the need around infrastructure that is going to be necessary, around information systems, care coordination, and data management,” said Doctor VanderLaan. “At least as most people currently see it, the best solution lies in coordinated systems of care. I think that’s a very important market pressure that also will impact physicians.”

Despite the multitude of challenges in the current environment, Michigan’s history of physician organizations’ involvement in health care delivery and early adoption of innovative payment or delivery models have left us better situated than many other states. However, in order for Michigan to maximize its success in the future, physicians must continue to play an important role in the design of the new delivery systems that emerge from new payment models.

“In terms of all of the consolidation, I would say that it provides a pretty good opportunity for physician leadership,” said Doctor VanderLaan. “As these systems form and as much of the provider community consolidation takes place, it would certainly be our hope that it is done under physician leadership, because at the end of the day, what we all want is optimal patient care. We want the patients to have appropriate care and good outcomes at the best possible cost. The physicians are really best situated to lead that charge.”

If physicians do not take advantage of the opportunities to lead the health system forward in terms of improved outcomes at more effective costs, they may not like the eventual results.

“I would say the major thing is to become involved, because I think groups are looking for physicians to come up with solutions; and if they don’t, then someone else will,” said Doctor Keshishian.

In our next installment, we will explore physician leadership roles, especially in physician organizations and independent practice associations.

Stacey Hettiger is Manager of Health Care Delivery at MSMS.
Paul Natinsky is Managing Partner of Creatavision Partners, LLC, a Royal Oak, MI-based marketing, communications and digital media firm. Joe Neller is Manager, Physician Organization Liaison at MSMS.

After Big Wins on Election Night, What Do We Do Now?

By Stacy Sellek

“W hat do we do now?” Robert Redford’s character utters this famous last line of “The Candidate” after winning his rookie senate race. But unlike fictional senator-elect Bill McKay, MSMS’s goals for the year extend far beyond winning elections. We’ve hit the ground running in lame duck to pursue victories for medicine on the legislative front, too.

“Through legislative channels, we physicians have a responsibility to protect the doctor-patient relationship and preserve patients’ access to quality health care,” said MSMS President John G. Bizon, MD.

Lame Duck Sausage

The comparison between making laws and making sausage is the lowest-hanging fruit of political analogies, but it helps articulate what typically keeps many in the medical profession from getting involved in this process. Despite the general distaste, though, it is important to remember that enduring a little sausage-making is worth the potential long-term payoffs for your patients and your profession.

That said, MSMS is working with lawmakers in Lansing to pass sound health policy for patients and the medical profession based on goals outlined in the legislative agenda.

Top on our lame duck agenda? Pushing the “Patients First Reform Package” (a.k.a., tort reform bills, SB 1115-1118) through the Senate, after four committee hearings and countless testimonies throughout the year. The bills would help mitigate the need for defensive medicine so physicians don’t have to fear repercussions for following the standard of care.

Other bills we’re monitoring closely:

• Blue Cross Conversion – SB 1293 and 1294 would allow for the mutualization of Blue Cross Blue Shield of Michigan. Passed Senate; in House Insurance Committee.

• Nurse Practitioner Scope – SB 481 would broadly define and expand the scope for advanced practice registered nurses to include diagnosis, intervention, treatment, and more. In Senate Health Policy Committee.

• Physical Therapist Scope – HB 4603 would eliminate the requirement of a prescription from a physician for physical therapy services. In House Health Policy Committee.

• Impaired Drivers – SB 402 and 403 would protect physicians from liability for reporting impaired drivers to the Secretary of State’s office. Passed Senate; in House Transportation Committee.

• Expedited Partner Therapy – House Bill 5934 would amend the Public Health Code to allow for expedited partner therapy for the treatment of chlamydia and gonorrhea. In House Health Policy Committee.

Tax & Attacks

“We believe that almost any legislative action that benefits physicians ultimately will end up helping our patients, as well,” said Doctor Bizon. “The totality of our advocacy efforts over the years demonstrates this.”

How effective has MSMS been in advocating for doctors and patients in recent years?

This year, MSMS helped to stop proposed budget cuts to Medicaid physician reimbursement and helped to lessen a massive proposed cut to graduate medical education (GME) funding. Maintaining Medicaid eligibility and funding – and GME funding – year after year has been no small feat in an age of recession.

Under our policy of supporting and attempting to achieve mental health parity, MSMS took a step in that direction by supporting legislation mandating insurance coverage for autism treatment and services. The bill was signed into law in the spring. In addition, MSMS made safety a priority by supporting legislation requiring schools to have regulations in place to deal with athletes who suffer concussions while playing school sports. The governor recently signed this into law.

Stopping an inequitable physician tax and repealing the onerous Michigan Business Tax lessened the financial and administrative burdens on medical practices. Defeating (near) annual legislative attacks on tort reform laws, passing liability protections for physicians who volunteer, and enabling you to express sympathy without legal repercussions protected your profession by bolstering Michigan’s stable liability climate. This helps us attract and retain quality physicians in Michigan. 
And passing the statewide smoking ban was a monumental win for everyone in the state, particularly those with chronic health conditions.

Two-way Street
No matter how they end up voting, lawmakers do remember those who take time to make their voices heard in person. As physicians, you have a golden opportunity – and an obligation – to meet with your legislators, build relationships with them, educate them about health care issues, and speak up for your patients and your profession. Term limits make this even more crucial.

MSMS offers members – and friends of medicine – the opportunities and the means to build working relationships with legislators, become a resource for them on health care policy issues, and help drive medicine's agenda. Participating in the “Doctor of the Day” program in Lansing is a great way to understand the legislative process, meet your lawmakers, and have an impact on health care policy in the state. MSMS will make all arrangements, accompany you, and provide materials.

Can’t come to Lansing? Reach out to build a working relationship with your lawmakers in the district. Send them your local contact information or call them at their district office and offer to be a resource on health policy issues. Take them out for coffee to address pending legislation.

Another way to make an impact and help accomplish our legislative goals is to join MDPAC (www.mdpac.org), to help elect pro-medicine candidates. MDPAC enables you to contribute, engage, unite and lead at the grassroots level of advocacy and politics.

As difficult as it is to do right by 16,000+ individual physicians when vetting issues (or candidates) to support, MSMS tries diligently to be as representative of all members and their beliefs as possible. We may not always succeed in that aim, but that is always the goal. After all, there is no such thing as a candidate or elected official who agrees with MSMS on everything. And vice versa.

That is why it is up to us – you – to be consistently engaged and constantly vigilant. MM

Think You’re Done with Meaningful Use? Think Again.

Now that you’re done with the first step toward meaningful use, be sure to maintain your documentation and collateral for audits.

By Joseph Dylewski

Since its inception in 2009, Meaningful Use, and the reimbursement tied to it, has occupied many of our agendas. As we approach the finish line to receive the maximum reimbursement, many are focusing their efforts on eligibility and attestation.

Media and software companies have let us know, ad nauseam, about the requirements and what must be done to meet them. Independent organizations and Regional Extension Centers, such as M-CEITA, have provided resources in an effort to help us select an Electronic Health Record (EHR) solution, re-engineer our processes and workflow, adopt the solution, and lead us on the path to attestation. Well, now it’s time to “open the books.”

For the most part, HITECH (Health Information Technology for Economic and Clinical Health) has been associated with Meaningful Use. However, Meaningful Use is only one component of HITECH. In addition to Meaningful Use, The HITECH Act actually consists of additional components that include improved HIPAA privacy and security provisions, funding for education and support of EHR adoption, improved Health Care quality and safety, and audits of all of the above.

The Centers for Medicare and Medicaid Services (CMS) has contracted with multiple firms to conduct Meaningful Use audits of certified EHR technology as required in section 13411 of the HITECH Act. The HITECH Act provides the Secretary of Health and Human Services (HHS), or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any organization receiving an incentive payment.

During these audits, the firms are requesting all of the files that support your Meaningful Use attestation within a 14-day window. A portal is provided to upload all of the supporting documentation. The selection of Eligible Providers appears to be random at this stage. However, evidence suggests that a portion of the audits will target providers that attested in year one and chose not to attest in year two.

To prepare for these audits, it is best to understand where this documentation is located and how to extract the necessary information from your EHR application. Most software that is used contains prepared reports.

One report, however, that is often overlooked is Meaningful Use core measure 15. Core measure 15 requires that eligible providers “conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process”. Identified security deficiencies must be corrected within the reporting period.

Due to the nature of core measure 15, it is very difficult – if not impossible – for your EHR vendor to assist, let alone provide, the necessary process, documentation, and collateral. In addition, by purchasing and adopting a “HIPAA Compliant” EHR solution, it does not necessarily translate to adherence to core measure 15. It is best to be certain that an appropriate Risk Analysis and subsequent Risk Management Plan was conducted and developed, respectively.

Eligible physicians/providers have worked relentlessly and expended significant resources to achieve Meaningful Use objectives. Now that the first step in this goal has been achieved, it is equally important that the momentum is continued. Maintain the documentation and collateral, understand the reports generated within your EHR application, and be prepared to present this information in short order.

The author is Managing Director, Health Care Management, LLC, and Assistant Professor at Madonna University.

Newborns and young infants represent a population at increased risk for the burden of severe pertussis and influenza-related morbidity and mortality. In Michigan, there has been a troubling and steady increase in pertussis over the past decade, peaking in 2010 with more than 1,500 cases reported. But these numbers cannot convey the human cost of this disease. In the spring of 2012, the worst case scenario occurred in southeast Michigan when an infant died of pertussis – the baby was only two months old.

Preventable pediatric deaths from the flu are just as somber. While flu seasons vary in severity, during nine recent flu seasons, the number of influenza-associated pediatric deaths ranged from 46 to 153; in Michigan there were six influenza-associated pediatric deaths during the 2010-11 influenza season. Pediatric deaths associated with influenza are more common in children with high-risk conditions; however, they frequently occur in healthy children as well.

Vaccination is the best protection we have for reducing the risk of illness, hospitalization, and death from influenza and pertussis. Babies less than six months of age cannot receive a flu vaccine. Children should get five doses of DTaP, one dose at each of the following ages: two, four, six, and 15-18 months, and four to six years, to be protected from pertussis. Another important strategy to protect vulnerable infants is to vaccinate those around them, forming a cocoon of protection. Anyone in close contact with a baby should receive both flu and Tdap vaccines, including:

- Pregnant women (protection is passed on from mother to baby);
• Parents, grandparents, and household members including brothers and sisters;
• Babysitters and out-of-home caregivers, including daycare workers;
• Health care personnel (HCP) in hospitals and clinics;
• Any loved ones who visit the baby.

Despite the Advisory Committee on Immunization Practice’s (ACIP) recommendation for all people six months and older to receive an annual flu vaccine, many populations did not receive a flu vaccine to protect themselves and vulnerable infants during the 2011-12 season.

• Nationally, fewer than half of pregnant women received a flu vaccine (47 percent).
• Only 67 percent of HCP received a flu vaccine nationally; the Healthy People 2020 goal is 90 percent.
• In Michigan, fewer than half (46 percent) of the children six months through 17 years old received a flu vaccine, compared to 52 percent nationally.
• Among Michigan adults, only 31 percent of adults 18 through 64 years of age and 62 percent of adults 65 and older received a flu vaccine; national rates were 33 percent and 65 percent, respectively.

There are multiple vaccine formulations that protect against pertussis. In addition to children receiving five doses of DTaP, adolescents should routinely receive Tdap at 11-12 years of age. Also, persons 13 years of age and older without a documented dose should receive Tdap as soon as feasible. Despite these recommendations, vaccination coverage for 19-35 months of age for the fourth DTaP dose is 81.7 percent in Michigan, and Tdap vaccination is a mere 8.2 percent among US adults 19-64 years of age.

Moreover, although the ACIP recommends that all HCP receive a Tdap vaccination, as of 2010 only 20 percent of HCP nationally had been vaccinated. These numbers represent a significant opportunity to protect more adolescents and adults through vaccination, thereby protecting our susceptible infants.

Since only one dose of Tdap vaccine is currently indicated and some children six months through eight years of age may need more than one dose of flu vaccine to be fully protected, it is important to assess a patient’s immunization history and to record a dose if given in your office. The Michigan Care Improvement Registry (MCIR) is a lifespan immunization registry that can be used to track and record immunizations.
The members of the Michigan State Medical Society remember with respect their colleagues who have died.

George H. Cameron, MD
Ann Arbor, died June 29, 2012, at the age of 83.

Thomas L. Haynes, MD
Grand Rapids, died October 16, 2012, at the age of 63.

William H. Henderson, MD
Boynton Beach, FL, formerly of Grosse Pointe, died October 2, 2012, at the age of 90.

Seymour Krevsky, MD
Bloomfield Hills, died July 11, 2012, at the age of 93.

Richard L. LaMont, MD
Novi, died January 20, 2012, at the age of 83.

William H. Morse, MD
Sarasota, FL, formerly of Northville, died July 31, 2012, at the age of 84.

James D. O’Brien, MD
Hilton Head, SC, formerly of Grand Rapids, died October 1, 2012, at the age of 83.

David A. Schultz, MD
Adrian, died September 21, 2012, at the age of 58.

Narinder K. Sherma, MD
Farmington Hills, died November 16, 2012, at the age of 84.

Eber B. Sherman, MD
Boyene Falls, formerly of Eaton Rapids, died September 9, 2012, at the age of 68.

James H. Tisdel, MD
Bloomington, MN, formerly of Port Huron, died September 29, 2012, at the age of 90.

IN MEMORY

If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, the physicians’ own charity, please contact Rebecca Blake, Director, MSMS Foundation, 120 W. Saginaw, East Lansing, MI 48823, call 517-336-5729 or send e-mail to rblake@msms.org.
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:** 8-6-2012 through 8-10-2012
Mahmood Tark Bakri, MD
Monroeville, PA
43-01-061241
08/06/2012
Reinstated with Probation
Douglas Ralph Rudde, Jr, MD
Las Vegas, NV
43-01-074945
09/05/2012
Fine Imposed, Reprimanded, Suspended, Sister State Disciplinary Action
Failure to Report/Comply
Robertta G. Kurtz, MD
Madison, WI
43-01-038245
08/06/2012
DSC/BD Vacated Final Order
Dated 06/13/12
Remanded back to Department for Further Proceedings

Charles Andrej Mosimba, MD
Bemidj Springs, MI
43-01-089193
08/06/2012
Summary Suspension Dissolved, Revoked – Fine Imposed
Negligence – Incompetence, Unprofessional Conduct, Lack of Good Moral Character, Technical violation of the Michigan PHC
Baljinder Singh Panu, MD
Oak Park, MI
43-01-066542
09/05/2012
Suspended
Negligence – Incompetence, Technical Violation of the Michigan PHC
Michele Renee Ritter, MD
Pontiac, MI
43-01-070661
08/06/2012
DSC/BD Vacated Final Order
Dated 06/13/12
Remanded back to Department for Further Proceedings
Raymond Jay Wetzman, MD
West Bloomfield, MI
43-01-030107
08/06/2012
Reclassified w/Full & Unlimited License
Michael Ross Jenkins, DO
Rochester Hills, MI
51-01-007574
08/06/2012
Suspended, Sister State Disciplinary Action
Failure to Report/Comply
Report Dated: 8-13-2012 through 8-17-2012
R. Charles Medlar, MD
Jackson, MI
43-01-036871
07/24/2012
Summary Suspension Dissolved

**Report Dated:** 8-26-2012 through 8-31-2012
Fares Fahmi Yasim, MD
Livonia, MI
43-01-079049
08/30/2012
Fine Imposed, Probation
Negligence – Incompetence, Lack of Good Moral Character, Drug Diversion

**Report Dated:** 9-3-2012 through 9-7-2012
Martin E. Testler, MD
Southfield, MI
43-01-028325
09/05/2012
Probation, Reprimanded, Fine Imposed
Failure to Meet Cont. Ed. Requirements

**Report Dated:** 9-10-2012 through 9-14-2012
Nan Beth Alt, MD
Grandville, MI
43-01-045669
09/14/2012
Summary Suspension
Unethical Business Practice, Permitting Unlicensed Practice, Violation of General Duty/Negligence, Lack of Good Moral Character

**Report Dated:** 9-17-2012 through 9-21-2012
Zufiigar Ali, MD
a/k/a Ali Jufiagar
Fremont, CA
43-01-040527
10/19/2012
Fine Imposed, Sister State Disciplinary Action
Failure to Report/Comply
Nathan Bining, MD
Livonia, MI
43-01-071275
10/19/2012
Reprimanded
Failure to Meet Cont. Ed. Requirements
William Robert Fry, MD
Roanoke, VA
43-01-080911
10/19/2012
Reprimanded, Sister State Disciplinary Action
Failure to Report/Comply
Sheldon L. Gonte, MD
Sterling Heights, MI
43-01-051492
09/19/2012
Fine Imposed
Negligence – Incompetence

**Report Dated:** 9-24-2012 through 9-28-2012
Peter R. Nwoke, MD
Grosse Pointe Woods, MI
43-01-082666
09/27/2012
Summary Suspension
Unethical Business Practice, Lack of Good Moral Character, Criminal Conviction, Unprofessional Conduct, Failure to Report/Comply
David V. Vu, MD
Oklahoma City, OK
43-01-042655
09/25/2012
Probation, Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements

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. If a licensee can not practice for a minimum period of three years; if the violation involved controlled substances, the license can not practice for a minimum of five years.
Suspension – a licensee can not practice for a specified period of time.
Revocation – 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.
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.
Every year on the fourth Saturday of October, making a difference has become the thing to do all across the United States. That day brings out organization members, students, families, and citizens to help their neighbors and people in their communities they don’t even know in unexpected ways. One of the efforts doctors and their families make every year is the collection and delivery of personal care items to benefit domestic abuse victims housed in local crisis shelters around the state.

For several years, the AMA Alliance, and state and county Alliances have spent numerous hours filling, collecting, and distributing thousands of bags for the “Doctors & Their Families Make a Difference” effort. It is an annual “rite of fall” that is near and dear to the MSMS Alliance, no matter how busy our lives are at this time of year.

As a physician’s spouse, I have been fortunate to enjoy a very comfortable life. My husband and I have two wonderful children and three “brag-worthy” grandchildren. Because of this, I have come to realize that one of the ways to express my joy and appreciation for my good life is to volunteer in ways and places where I can make a difference for others.

In addition to our annual “pink bag” effort, I also volunteer at a local food pantry. Giving out coats to people when the weather turns cold, finding a crib for a family with a baby on the way, and reading to young children in the hope that they will learn to love reading are other volunteering opportunities that I value.

We can all make a difference in some way. Even if your life is extremely busy or you feel you have no talent to offer, giving back to your community is a great way to help make a difference, and it feels wonderful. Challenge yourself to find ways – big or small – to make a difference in your area.

Thank you to MSMS, MSMS Alliance, MSMS Foundation, The Doctors Company, and MSMS Physicians Insurance Agency for making a difference again this year!

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

Welcome to These New MSMS Members

Roger (Ragi) Abiragi, MD, New Baltimore
Adil Ali, MD, Ypsilanti
Liaqat Ali, MD, Monroe
Babatunde Hamed Almaroof, MD, Swartz Creek
Casey Turner Ashby, DO, Kalamazoo
Mark Korea Banno, MD, Farmington Hills
David M. Bartholomew, MD, Battle Creek
Joel Wells Barton, MD, Okemos
Ronald H. Bradley, DO, Saginaw
Dana Michael Busch, DO, Waterford
Sylmara E. Chatman, MD, Southfield
Rodney L. Dewyer, MD, Chelsea
Andrew Egger, MD, Ypsilanti
Abby S. Fedewa, MD, Detroit
Patrick Thomas Gartland, MD, Traverse City
Zuhair Ghanem, MD, Laurium
Ali M. Ghasham, MD, Battle Creek
Steven A. Gill, MD, Troy
Jimmy Charbel Haouilou, MD, Saint Clair Shores
Aliya Courtney Hines, MD, PhD, Grosse Pointe Park
Rebecca A. Hong, MD, Ann Arbor

Noura Farid-Shaya Mansour, MD, Troy
Matthew A. McKee, MD, Saint Clair Shores
Haile M. Mezghebe, MD, Metamora
John Bevan Millett, MD, Walker
Parvathy Nair, MD, Ypsilanti
Rebecca G. Poetschke, DO, Tecumseh
Vernon Eugene Proctor, MD, Baldwin
Schuyler Andrew Rogg, MD, Grand Rapids
Mahmood Saddiqui, MD, Battle Creek
Siddiqui M. Salim, MD, Detroit
Benjamin R. Schipper, MD, Grandville
Robert Seiler, DO, Okemos
Lili Sheibani, MD, Ann Arbor
Robert L. Steele, MD, Saginaw
Karen Torres, MD, Detroit
Anupama Varadarajan, MD, Clinton Township
Dinesh Vyas, MD, Lansing
Wendy Wahl, MD, Ypsilanti
Steven G. Walvisch, MD, Mount Pleasant
Eugene Zolotarevsky, MD, Ypsilanti
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Lean Physician Practice Innovation: Finding the Time to Deliver Great Health Care

Webinar Date (Free!):
Thursday, December 6, 2012
Time: 7:00 to 8:00 p.m.
Date: Wednesday, January 23, 2013
Time: 9:00 a.m. to 4:30 p.m.
Location: Eagle Crest Resort, Ypsilanti
Date: Wednesday, February 27, 2013
Time: 9:00 a.m. to 4:30 p.m.
Location: Eagle Crest Resort, Ypsilanti
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians and their office staff.

Transitioning to Accountable Care Organizations

Date: Wednesday, January 30, 2013
Time: 9:00 a.m. to 3:30 p.m.
Location: Somerset Inn, Troy
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.

Primary Care Webinar Series

Date: Thursday, January 10, 2013
Mobile Apps and Social Networking
Date: Thursday, March 7, 2013
Patient Engagement Strategies and Satisfaction
Date: Tuesday, May 21, 2013
Physician-led Care Coordination and Health Literacy
Time: 7:30 p.m. to 8:30 p.m.
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org
Intended for: Physicians, nurses, and all other health care professionals.

MSMS Physician Executive Development Program: Winter Series

Date: Wednesday, February 13, 2013
Time: 8:45 a.m. to 5:00 p.m.
Date: Tuesday, March 19, 2013
Time: 9:00 a.m. to 3:45 p.m.
Location: The Henry Center for Executive Development, Lansing, Michigan
Two Webinars on Management Skills
Date: Monday, February 25, 2013
Time: 7:00 to 8:00 p.m.
Date: Wednesday, March 6, 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: Wednesday, March 13, 2013
Time: 9:00 a.m. to 3:30 p.m.
Location: Somerset Inn, Troy
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.

To Register Online:
www.msms.org/eo
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MSMS Foundation
PO Box 950
East Lansing, MI 48826-0950
Fax:
517-336-5797
Phone:
517-336-5785
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“Occupational Protection” provides the kind of protection and peace of mind that is especially important to physicians. That’s why MSMS Physicians Insurance Agency makes it available to you.

No other agency specializes in physicians—and no other agency reinvests in advocacy for physicians. For more information about disability insurance from MSMS Physicians Insurance Agency, please contact Heather Hamilton at hhamilton@msms.org or 517-202-2604. Find out more about MSMS PIA at www.msmsinsurance.org.

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Visit MSMS Hot Topics at: www.msms.org/hottopics
Or scan this QR code with your smartphone.
Wednesday, December 5, 2012 • 11:15 a.m. – 5:25 p.m.
5:25 – 6:15 p.m. Hors d’oeuvre reception

**COURSE DIRECTOR**
Thomas A. LaLonde, MD
Chief, Division of Cardiovascular Services, St. John Hospital & Medical Center; Associate Clinical Professor of Medicine, WSU School of Medicine, Detroit, MI

**SYMPOSIUM**

**Hyperlipidemia: 2012 Perspective**
James Maciejko, MS, PhD
Director, Lipid Clinic, St. John Hospital & Medical Center; Associate Professor, Department of Internal Medicine, WSU School of Medicine, Detroit, MI

**Resistant Hypertension: Therapeutic Options, When To Refer**
Susan P. Steigerwalt, MD
Director of Hypertension Research and Hypertension Clinic, St. Clair Specialty Physicians; Director of Resistant Hypertension Clinic, Providence Hospital; Clinical Associate Professor, WSU School of Medicine, Detroit, MI

**Advanced Heart Failure: When Medicines Aren’t Enough**
David Lanfear, MD
Director, Advanced Heart Failure Clinic, St. John Hospital & Medical Center; Senior Staff, Advanced Heart, Failure and Cardiac Transplantation; Research Scientist, Center for Health Services Research, Henry Ford Hospital; Assistant Professor, WSU School of Medicine, Detroit, MI

**Atrial Fibrillation: Strategies For Optimal Management**
Luis A. Pires, MD
Medical Director, Heart Rhythm Center, St. John Hospital & Medical Center; Associate Professor, WSU School of Medicine, Detroit, MI

**Device Therapy For Cardiac Arrhythmias: 2012 Update**
Ali H. Shakir, MD
St. John Hospital Cardiology, Fellowship; Faculty Clinical Assistant, Professor of Medicine, WSU School of Medicine, Detroit, MI

**Percutaneous Coronary Revascularization: Evolution To 2012**
Hiroshi Yamasaki, MD
Director Interventional Cardiology, Director Interventional Fellowship Program, Faculty, Cardiology Fellowship Program, St. John Hospital & Medical Center, Detroit, MI

**Peripheral And Carotid Intervention: Options In The Cath Lab**
Thomas Davis, MD
Medical Director, Cardiac Cath Lab and Peripheral Vascular Intervention, Faculty, Fellowship Program, Department of Cardiology, St. John Hospital & Medical Center, Detroit, MI

**Structural Heart Disease: Where Are We Going? The Heart Team Approach**
Sanjay Batra, MD
Chief, Division of Cardiothoracic Surgery, St. John Hospital & Medical Center, Detroit, MI

**ACCREDITATION**
St. John Hospital & Medical Center is accredited by the Michigan State Medical Society to provide continuing medical education for physicians. St. John Hospital designates this live activity for a maximum of 4.0 AMA PRA Category 1 Credit(s)™! Physicians should only claim credit commensurate with the extent of their participation in the activity.

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

**Continuing Medical Education: St. John Hospital & Medical Center Upcoming Programs 2013**

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<tr>
<th>Date</th>
<th>Program</th>
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<tr>
<td>March 6, 2013</td>
<td>Surgery Symposium</td>
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<td>April 24, 2013</td>
<td>Pediatric Symposium</td>
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<td>June 5, 2013</td>
<td>Internal Medicine Symposium</td>
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<td>September 11, 2013</td>
<td>Psychiatry Symposium</td>
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<td>October 23, 2013</td>
<td>Family Medicine Symposium</td>
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<td>December 4, 2013</td>
<td>Cardiology Symposium</td>
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For more information contact:
313-343-3877 as these may be subject to change.
The theme of this month’s issue is membership. While membership in the MSMS is vital, I’d like to mention a related area that needs involvement by state physicians, the Michigan Doctors’ Political Action Committee (MDPAC).

After election season 2012, the last thing many of you want to read about is politics. Yet Michigan’s legislative, executive and judicial structures have a direct impact on how you practice medicine 24/7. If you think we only need turn attention to what happens in Lansing every two years or so, prepare yourself for some unpleasant surprises.

The MDPAC proved very effective for Michigan physicians in the November elections, with a 92 percent success rate on its endorsements and supports. Our efforts played a part in re-electing rule-of-law state Supreme Court Justices Markman and Zahra.

Yet despite its successes, MDPAC is not on the radar screens of most MSMS members, and their involvement shows it. Approximately seven percent of MSMS members are also members of MDPAC, which means that 93 percent of us get a free ride on its successes. Many of our physicians attribute the success of our legislative efforts to the MSMS Government Relations Department. Indeed, this team has been very effective, but MDPAC provides the fuel needed to drive our legislative agenda as physicians. And too few of us are doing our part.

No doubt there are many reasons physicians aren’t involved in supporting MDPAC. Growing paperwork burdens, 70-hour weeks, and ever-tighter profit margins leave physicians unwilling to invest time or funds on political issues. I hear many excuses for begging out of MDPAC involvement. “I don’t want to get involved in politics... I prefer making contributions to my own individual candidates... I’ll be swamped with phone calls for contributions.”

Politics can also lead to divisions, even among those with shared interests. MSMS, and in turn MDPAC, often deals with tough, contentious issues, such as stem cell research, abortion, or single-payer proposals.

All these excuses sound reasonable. Yet not joining MDPAC also weakens the practice of medicine in Michigan, and ultimately, your own personal interests. Politics will happen, whether you contribute or not. The coming year will be an off one for elections, but major issues, including medical liability and scope of practice, will be in front of legislators and state courts. Major Medicare cuts that have been forestalled for 11 years are now back on the docket, and will occur without strong political action. As a lone (and busy) physician, can you make the contributions and vet the candidates who will work with MSMS to enact sound health policy in Michigan? MDPAC will.

On the candidates and issues endorsed and supported by MDPAC, you may not support every single one, but I’m pretty sure you support the majority of them. When dealing with shades of gray, we all must be willing to compromise for the good of medical practice in Michigan. There’s an old political adage: If you want to elect someone who agrees with you all the time, you should run for office yourself.

MDPAC has been fighting the good fight for physicians in Lansing. But it’s still missing something important, one more added element that will make it a much more effective political force in health care – you. MM

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