Opioid Abuse Puts Physicians between a Rock and a Hard Place
But Resources Can Help Them Lead the Debate on How to Rein It In

ALSO IN THIS ISSUE
- The Role of Informed Consent in Opioid Prescribing
- MSMS Goes to Bat for Specialists to Earn Uplifts Through BCBSM PGIP
- What to Tell Your Patients About Electronic Health Records
- How (and How Not) to Reform Medical Education
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COVER STORY

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The July/August 2013 Michigan Medicine contained articles about the importance of using the Michigan Automated Prescription System to track prescriptions and the problem of opioid use on the rise. This final installment reports the risks of opioid over- and misprescribing, and ways physicians can protect their practices and their patients.

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To describe John E. Billi, MD, as perceptive would be a huge understatement. His ability to identify problems in health care, his openness to learning different perspectives, and his willingness to try on different ideas is unique, and – to hear him compare it to nature – nothing short of poetic.

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BE BOLD WITH LEAN BEEF

Heard the good news about lean beef? The latest research presents a new way of thinking: lean beef can be part of a solution to one of America’s greatest health challenges—eating for a healthy heart. A study published in the American Journal of Clinical Nutrition found that participants in the BOLD (Beef in an Optimal Lean Diet) study experienced a 10% decrease in LDL cholesterol from baseline when they ate lean beef daily as part of a heart-healthy diet and lifestyle containing less than 7% of calories from saturated fat.*

Setting the Record Straight
This ground-breaking clinical study substituted lean beef for white meat as part of an overall heart-healthy diet and found the improvements in LDL cholesterol seen on the beef-containing diets were just as effective as DASH (Dietary Approaches to Stop Hypertension).

MANY LEAN CUTS
Lean beef is easily served with vegetables, whole grains and low-fat dairy—improving taste, satisfaction and providing essential nutrients. And many of the most popular cuts of beef—like Top Sirloin steak, Tenderloin and 95% lean Ground Beef—meet the government guidelines for lean.

TEN ESSENTIAL NUTRIENTS
Packed with high-quality protein, lean beef provides a satisfying, nutrient-rich experience. A 3-ounce serving of lean beef contains 150 calories on average and is a good or excellent source of ten essential nutrients, including iron, zinc and B-vitamins.*

PART OF A HEART-HEALTHY PLAN PATIENTS WILL LOVE
Lean beef can be a deliciously welcome and satisfying choice in a heart-healthy diet. Help your patients increase meal flexibility by including lean beef among other heart-healthy choices on their shopping lists.

Learn more about the many nutritional and heart health benefits of lean beef at:

BEEF nutrition.org

* Subjects that consumed the BOLD diet experienced a 10.1% decrease in LDL cholesterol compared to baseline. In comparison to the Healthy American Diet, subjects experienced a 4.1% decrease in LDL cholesterol on the BOLD diet.


The Michigan Beef Industry Commission
www.mibeef.org
The Role of Informed Consent in Opioid Prescribing

By Daniel J. Schulte, JD

QUESTION:
I am aware that physicians must obtain informed consent from their patients for treatment. My practice involves pain management by prescribing opioids. Are there additional requirements for informed consent in this setting? If so, can you please give me some direction as to what I must do to ensure that I have obtained proper informed consent from my patients?

ANSWER:
All physicians must obtain informed consent from their patients prior to providing treatment. Failure to achieve informed consent is malpractice. What actions necessary to properly obtain/document informed consent are not expressly set forth in any law. Whether informed consent has been achieved depends on the applicable standard of practice and will be influenced by a physician’s specialty.

Given the potential for addiction, misuse, et cetera, when opioids are used in treating patients, documentation of informed consent for the treatment is critical. These concerns (i.e., addiction and misuse) should cause physicians to consider adding to their standard informed consent forms (which explain the specific information given to the patient relative to his/her condition or disease, consequences if the condition or disease is left untreated, appropriate treatment options, risks inherent in the treatment and the responses to specific questions regarding the treatment, the associated risks, likely benefits and other standard informed consent information) provisions that specifically deal with the responsibilities/accountability of the patient, such as:

1. The need for the patient to continually keep you informed of information relevant to your continued treatment (e.g., side effects experienced, unexpected changes in condition, tolerance to the drug, addictive effects experienced, etc.)
2. The patient’s agreement to communicate to other physicians/prescribers (whether they be the patient’s primary care provider or other health care provider) that they have received a prescription for opioids from you
3. An acknowledgement of your right/ability to access a MAPS report on the patient to ensure compliance, absence of doctor shopping, and other misuse of the drug(s)
4. Your policies relating to and the repercussions of missed appointments and requested follow up, the handling of “emergencies,” showing up without an appointment, etc.
5. Your right to terminate the physician-patient relationship for not following a procedure, suspected abuse of the drug, or any other unacceptable behavior

Communicating informed consent orally may be acceptable in some settings; however, when the treatment involves opioid use, the best practice is to put it in writing, adding the elements of patient responsibility/accountability listed above so that a written treatment agreement is formed. In addition, you should chart in the patient’s record ongoing conversations and other observations regarding consequences and risks of the treatment.

If your treatment plan includes prescribing controlled substances, you should consider taking this approach even further, adding...
to your informed consent/treatment agreement document:
1. Limits on replacing lost drugs, unscheduled refills, changes to prescriptions
2. An agreement to random drug screens
3. Consenting to education on the signs of addiction and associated side effects
4. Limits to in-state/single pharmacy for filling prescriptions

Unfortunately, there is not a single form for informed consent/treatment that can be used for all physicians who prescribe opioids routinely in treating their patients. Many of the elements of this document will be the same for all patients. Your specific knowledge of the patient, his/her condition, and other factors known to you may cause you to add to these standard provisions.

Daniel J. Schulte, JD, MSMS Legal Counsel, is a member of Kerr, Russell and Weber, PLC.
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The recent death of James Gandolfini, who played fictional mafia boss Tony Soprano on the hit TV series The Sopranos, and recent malpractice cases are reminders that physicians and other health care providers need to be on alert for the risk factors of sudden cardiac arrest (SCA).

SCA is the unexpected loss of heart function, breathing, and consciousness. In SCA, the electrical system of the heart fails and, at times, a heart attack may occur concurrently.

About half of people who suffer SCA had no previous symptoms, such as fatigue, dizziness, and racing heart rate. Approximately 325,000 people in the US die from SCA annually. People who smoke or have coronary artery disease, have had a previous heart attack, have high cholesterol, and/or have a family history of heart disease have a higher risk.

These malpractice claims are representative of claims involving SCA:

- A 52-year-old patient had heartburn for over a week, and her physician treated this symptom. The patient had high blood pressure, elevated blood glucose, and normal cardiac enzymes. Her father had died at age 55 from a heart attack, and she had a family history of coronary artery disease. The physician only considered the diagnosis of heartburn and did not order serial cardiac enzymes, an EKG, or a cardiac consult. The patient died the next day from SCA.

- An obese patient had elevated triglycerides and complaints of burning in the chest with walking, but no shortness of breath or radiation of the burning sensation into the upper extremities. The physician had done an EKG a year earlier, which was abnormal, and did another EKG, which was also abnormal, with a computer reading of possible left ventricular hypertrophy. The physician thought this EKG was normal, as was his examination, but he did order a cardiology consultation. Prior to the consult, the patient died.

These tips can help providers avoid misdiagnosis of SCA:

- Consider the possibility of advanced cardiac risk in patients who:
  - Are overweight and unable to control their weight with diet and exercise
  - Have high blood pressure not responsive to medication
  - Have evidence of erectile dysfunction
  - Are glucose intolerant
  - Have consistently high cholesterol levels
  - Have a history of alcoholism

- Take into account other factors associated with SCA, including:
  - Incidence increases with age: men after age 45 and women after age 55
  - Men are two to three times more likely to have SCA than women
  - Personal or family history of heart rhythm disorders, congenital heart defects, heart failure, or cardiomyopathy
  - Use of illegal drugs (amphetamines or cocaine)
  - Nutritional imbalances (low potassium or magnesium levels)

Be Aware of the Risk of Sudden Cardiac Arrest That Killed Tony Soprano

Contributed by The Doctors Company

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

Navora G. Cuisson, MD  
Spring Lake  
Died August 28, 2013, at the age of 78.

Albert D. Engstrom, MD  
Whitehall  
Died September 7, 2013, at the age of 91.

Max A. Finton, MD  
Oakland  
Died August 9, 2013, at the age of 96.

Robert M. Jesson, MD  
Muskegon  
Died August 29, 2013, at the age of 89.

David A. Krevsky, MD  
Dearborn  
Died April 14, 2013, at the age of 89.

James W. Lyons, MD  
Beulah  
Died August 21, 2013, at the age of 96.

Louis E. May, MD  
Howell  
Died September 18, 2013, at the age of 91.

Doris A. Nelson, MD  
Sterling  
Died July 7, 2013, at the age of 47.

William G. O’Driscoll, MD  
Grand Rapids  
Died August 26, 2013, at the age of 85.

J. Jay Post, MD  
Grand Rapids  
Died September 2, 2013, at the age of 85.

Paul J. Van Portfliet, MD  
Grand Rapids  
Died September 14, 2013, at the age of 94.

IN MEMORY

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

For More Information

For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.
Prescription drug overdoses are named as the second leading cause of accidental death behind traffic crashes, and painkillers as the top narcotic contributing to death. A recent National Drug Assessment study shows that prescription narcotics are the second most abused drug (behind marijuana), surpassing cocaine, heroin, meth and crack.

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Physicians want to do the right thing when it comes to treating patients suffering from chronic pain. After all, the Hippocratic Oath begins, “First, do no harm…”

But most physicians don’t go to medical school to wind up policing their patients, enforcing rules or doling out punishment. Neither do they become physicians to launch drug empires.

Yet, when it comes to our nation’s and our state’s efforts to curb the growing abuse of prescription painkillers, they are in the unique and unenviable position of being stuck in the middle of these extremes – unless they arm themselves with information and step up to lead the debate about how to wrap our collective arms around this complex issue.

**Breaking Bad**

There’s no denying that prescription drug abuse is the fastest growing drug problem in the nation, and is growing problem in Michigan. In Michigan, the number of hospitalizations involving opioids increased 120 percent between 2000 and 2011 – from 9,157 to 20,191 hospitalizations – according to the Michigan Department of Community Health (MDCH).

The White House Office on National Drug Control Policy (ONDCP) conducts comprehensive reporting and strategy for each state. The Office’s plan called “Epidemic: Responding to America’s Prescription Drug Abuse Crisis” provides a national framework for reducing prescription drug diversion and abuse by supporting the expansion of state-based prescription drug monitoring programs (such as the Michigan Automated Prescription System); recommending secure, convenient and environmentally responsible disposal methods for unneeded medications; supporting education for patients and physicians; and reducing the prevalence of “pill mills” and doctor shopping through enforcement efforts.

From a law enforcement perspective, the ONDCP operates a High Intensity Drug Trafficking Areas (HIDTA) program in Michigan, which brings together drug control efforts of local, state, and federal law enforcement agencies. In designated HIDTA counties, the program provides agencies with coordination, equipment, technology, and additional resources to combat drug trafficking and its consequences in critical regions of the US. HIDTA counties in Michigan include Wayne, Oakland, Macomb, Washtenaw, Genesee, Kent, Kalamazoo, Allegan, Saginaw, and Van Buren.

Through interagency cooperation and consolidation of strategic and tactical information, the Michigan HIDTA fosters a comprehensive response to illicit drug activity.
by bringing together all available law enforcement resources in a united effort. The Michigan HIDTA feeds federal funding and investigative support services to 27 task forces throughout the state. In addition, 25 drug courts operate in Michigan to deal with offenders.

On the legislative side, nine states have passed some kind of law targeting “pill mills” (see sidebar): Georgia, Kentucky, Ohio, Tennessee, West Virginia, Texas, Louisiana, Florida and Mississippi. Currently, there is no pending legislation in Michigan.

**Marshaling Resources**

According to the MDCH 2012 Annual Survey of Physicians, about 61 percent of active physicians agree with the statement, “Almost all chronic pain can be relieved with treatment.” However, only three percent of those physicians say they are formally certified in pain management.

Medical schools do not typically offer pain management curriculum, so depending on their specialty, many physicians are left to pick up whatever they can in residency or through independent courses.

Since 2009, when MDCH started reporting on pain management, a majority of physicians have reported receiving a “little” or “some” training in managing pain. In 2012, more than half (54 percent) say they have had some training. About 34 percent of active physicians report having had little (24 percent) or no training (10 percent) in managing pain.

These statistics beg the question: where can physicians turn for education about chronic pain management and prescription drug abuse? The Michigan Department of Licensing & Regulatory Affairs (LARA) offers an abundance of resources, including a list of educational opportunities for physician about pain management.

Beyond seeking education, reporting is another important way physicians can help stem prescription drug abuse. States can launch their own Prescription Drug Monitoring Programs (PDMP) through the federal government to track controlled substances prescribed by authorized practitioners and dispensed by pharmacies. PDMPs serve a number of functions, including a list of educational opportunities for physician about pain management.

The Michigan Automated Prescription System (MAPS) collects prescription information on Schedule II-V controlled substances and allows physicians, dentists, pharmacists, nurse practitioners, physician’s assistants, podiatrists, and veterinarians to query the data for patient-specific reports. This enables practitioners to determine if patients are receiving controlled substances from other providers and to help prevent prescription drug abuse. Prescription data collected by pharmacies and dispensing practitioners are stored in a secure central database within MDCH.

MDCH reports that about four-fifths (81 percent) of active physicians report being aware of MAPS, and half (53 percent) report having used MAPS.

**An Ounce of Prevention**

As for what physicians can do help prevent and reduce prescription drug abuse overdose in Michigan, MDCH offers tips...
Dispel the perception that prescription medications are safer to abuse, and result in less shame if caught, than illegal drugs.

Encourage the proper disposal of unused medications (e.g., through community drug take-back programs). Drug take-back programs are comprehensive plans to address prescription drug abuse must include proper disposal of unused, unneeded, or expired medications. Providing individuals with a secure and convenient way to dispose of controlled substances will help prevent diversion and abuse of these substances and demonstrate sound environmental stewardship. States are encouraged to work with the DEA to conduct additional take-back events and educate the public about safe and effective drug return and disposal.

Promote involvement in local efforts to address this important health issue. The ONDCP’s Drug-Free Communities (DFC) Program mobilizes communities to prevent youth drug use by creating local data-driven strategies to reduce drug use in the community. ONDCP works to foster the growth of new coalitions and support existing coalitions through the

### State Entities & Their Roles

- **Controlled Substances Advisory Commission** – Monitors indicators of controlled substance abuse and diversion and to recommend actions to address identified problems of abuse and diversion.

- **Advisory Committee on Pain & Symptom Management** – The committee was charged with addressing issues pertaining to pain and symptom management, holding a public hearing to gather information from the general public and making recommendations to the legislature.

- **The Michigan Board of Medicine and Michigan Board of Osteopathic Medicine & Surgery** – Respond to complaints about inappropriate prescribing when it is identified. If a complaint is brought, an investigation is made, and it is confirmed that inappropriate prescribing has occurred, the Board can take action against the physician’s license or impose discipline of some kind. Often the DEA has already taken action, such as revoking the DEA license. Sometimes the US Attorney’s office has taken action as well, if fraud is involved.

- **The Michigan Board of Pharmacy** – Communicate what the Board considers to be minimum standards of practice for pharmacists caring for patients requiring pain control and presenting with prescriptions for controlled substances.

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### What’s a ‘Pill Mill’?

“Pill mill’ is a term used primarily by law enforcement entities to describe a physician, clinic, or pharmacy that is prescribing or dispensing powerful narcotics inappropriately or for non-medical reasons. “Pill mill” clinics come in all shapes and sizes, but investigators say more and more are being disguised as independent pain management centers. They tend to open and shut down quickly in order to evade law enforcement.

**TELLTALE SIGNS:**

- Accept cash only
- No physical exam is given
- No medical records or x-rays are needed
- You get to pick your own medicine, no questions asked
- You are directed to “their” pharmacy
- They treat pain with pills only
- You get a set number of pills and they tell you a specific date to come back for more
- They have security guards
- There may be uncommonly large crowds of people waiting to see the doctor

It is against federal law for a physician to prescribe pain medication without a legitimate medical purpose or outside the usual course of medical practice. If a prescription is deemed as not valid, a doctor could be charged with drug trafficking. This is a felony with the possibility of up to life in prison.
DFC grants. In FY 2011, the following Michigan coalitions received grants from ONDCP:

- Allegan County Community Mental Health Services
- Barry County Substance Abuse Task Force
- Birmingham Bloomfield Community Coalition
- Chippewa Valley Coalition for Youth and Families
- Drug Free Montcalm
- Eaton County Substance Abuse Advisory Group
- Garden City Community Coalition
- Grand Valley State University/AOD Partnership for Healthy Communities
- Greater West Bloomfield Community Coalition for Youth
- Healthy Youth Coalition of Marinette and Menominee Counties
- Holly Area Youth Coalition
- Ingham Substance Abuse Prevention Coalition, c/o Cristo Rey Community Center
- Jackson County Substance Abuse Prevention Coalition
- Kalamazoo County Substance Abuse Task Force
- Madison Heights Community Family Coalition
- Monroe County Substance Abuse Coalition
- Muskegon Community Health Project, Inc./Toward a Drug-Free Muskegon Community
- North Oakland Community Coalition
- Ottawa Substance Abuse Prevention Coalition (OSAP)
- Royal Oak Prevention Coalition
- Southeast Oakland Coalition
- SRSLY (Chelsea)
- Sterling Area Health Center
- The Detroit Recovery Project Coalition
- The Healthy, Safe and Drug-Free Schools and Communities Coalition (Grand Rapids)
- Tri-Community Coalition
- Advise patients to use prescription painkillers only as directed by a health care provider. Never sell or share unused medications with others.
- Prescribe painkillers only for the expected length of pain. Screen patients for potential substance abuse problems.
- Use the Michigan Automated Prescription System to identify improper prescribing of painkillers.

The author is senior manager of communications at MSMS.

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**October is National Substance Abuse Prevention Month**

Visit the Substance Abuse & Mental Health Services Administration website for resources and information: [www.samhsa.gov](http://www.samhsa.gov)
After several years of focusing predominantly on building primary care infrastructure, the Blue Cross Blue Shield of Michigan Physician Group Incentive Program – commonly known as PGIP – recently intensified its efforts to expand the number of specialty physicians eligible to receive increased professional fees, or “uplifts.” While specialists always could participate in PGIP through physician organizations, 2013 was the first year in which a significant number of select specialties were eligible for fee uplifts. The inclusion of specialists in the PGIP program continues the trend in health care payment models away from strict fee-for-service and toward fee-for-value, designed to create integrated delivery models in which systems of caregivers are accountable for population-based outcomes of patients.

Since its inception, BCBSM PGIP has been a source of confusion, and sometimes contention, for the physician community. The Michigan State Medical Society has dedicated a tremendous amount of time and effort attempting not only to explain PGIP to physicians, but also to advocate for changes to the BCBSM that will allow physicians to remain successful in delivering high quality care to patients. MSMS has advocated steadfastly for broader inclusion of specialists in PGIP fee uplifts, particularly since BCBSM has not provided any across-the-board annual updates to the professional fee schedule in recent years.

So how does the PGIP process work generally and how does it work specifically in the case of specialty physician uplifts? In 2005, when BCBSM created the PGIP incentive pool, which was intended to be an additional professional funding stream separate from the traditional fee-for-service reimbursement, it was determined there would be two components: a physician organization component and an individual physician component. The physician organization component funds the incentive pool and represents a set percentage of the allowed amount for most professional services. The physician component represents the approved amount of reimbursement that BCBSM commits to individual physicians (established fee schedule amount). BCBSM distributes incentive dollars from the physician organization component to the 43 physician organizations currently participating in PGIP twice annually. This distribution is calculated based on general participation in the program – such as attendance at the PGIP quarterly meetings – and the performance of the individual members of the physician organizations, defined as a combination of cost-effectiveness and quality patient outcomes.

Each physician organization determines how best to use the incentive dollars once they receive them from BCBSM. Most use these funds to build advanced practice infrastructure such as care registries or electronic medical records and some provide additional

<table>
<thead>
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<th>Specialties Eligible for Uplifts</th>
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<tr>
<td><strong>2011</strong></td>
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<tr>
<td>Oncology</td>
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<tr>
<td>Cardiology</td>
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| **2012**                        |
| Oncology                        |
| Cardiology                      |
| Emergency Medicine              |
| Gastroenterology                |
| Nephrology                      |
| Obstetrics/Gynecology           |
| Orthopedics                     |
| Allergy                         |
| Chiropractic                    |
| Critical Care                   |
| Endocrinology                   |
| Infectious Disease              |
| Neonatal Care                   |
| Neurology                       |
| Otolaryngology                  |
| Pain Management                 |
| Podiatry                        |
| Psychiatry                      |
| Psychology                      |
| Pulmonology                     |
| Physical Medicine               |
| Sports Medicine                 |
| Urology                         |

| **2013**                        |
| Oncology                        |
| Cardiology                      |
| Emergency Medicine              |
| Gastroenterology                |
| Nephrology                      |
| Obstetrics/Gynecology            |
| Orthopedics                     |
| Allergy                         |
| Chiropractic                    |
| Critical Care                   |
| Endocrinology                   |
| Infectious Disease              |
| Neonatal Care                   |
| Neurology                       |
| Otolaryngology                  |
| Pain Management                 |
| Podiatry                        |
| Psychiatry                      |
| Psychology                      |
| Pulmonology                     |
| Physical Medicine               |
| Sports Medicine                 |
| Urology                         |

| **2014**                        |
| Oncology                        |
| Cardiology                      |
| Emergency Medicine              |
| Gastroenterology                |
| Nephrology                      |
| Obstetrics/Gynecology           |
| Orthopedics                     |
| Allergy                         |
| Chiropractic                    |
| Critical Care                   |
| Infectious Disease              |
| Neonatal Care                   |
| Neurology                       |
| Otolaryngology                  |
| Pain Management                 |
| Podiatry                        |
| Psychiatry                      |
| Psychology                      |
| Pulmonology                     |
| Physical Medicine               |
| Sports Medicine                 |
| Urology                         |

| **2015**                        |
| Oncology                        |
| Cardiology                      |
| Emergency Medicine              |
| Gastroenterology                |
| Nephrology                      |
| Obstetrics/Gynecology           |
| Orthopedics                     |
| Allergy                         |
| Chiropractic                    |
| Critical Care                   |
| Infectious Disease              |
| Neonatal Care                   |
| Neurology                       |
| Otolaryngology                  |
| Pain Management                 |
| Podiatry                        |
| Psychiatry                      |
| Psychology                      |
| Pulmonology                     |
| Physical Medicine               |
| Sports Medicine                 |
| Urology                         |

PLUS: Most Other Specialties
bonuses to their physician members – including specialists – based on criteria internal to the physician organization. There are no requirements from BCBSM on how physician organizations use their incentive dollars, but there is an expectation that the funds be used to further the overarching PGIP goals of improving health care quality and transforming health care value.

In addition to incentive payments made to physician organizations, there are initiatives designed to enhance payments directly to their individual physician members. For instance, a PGIP primary care initiative provides enhanced reimbursement to those physicians who achieve designation as a patient-centered medical home (PCMH.) These are physicians who are nominated by their physician organization for having specific capabilities – such as open and extended scheduling access, electronic prescribing and care registries, care coordination and specialist referral processes – and for reaching patient outcome or cost-effectiveness thresholds. Physicians who receive PCMH designation can receive a 10-20 percent uplift on select preventive and office visit E&M codes when billed to BCBSM.

The process for eligible specialty fee uplifts is similar to the one traditionally used by BCBSM for PCMH designation. In 2013, physicians in seven specialties were eligible to be nominated by their physician organization to receive uplifts. Once a specialist receives a nomination, he or she is evaluated against a series of metrics to measure efficiency, utilization and quality. These metrics are specialty specific and are not designed to judge the quality of an individual physician or practice, but rather the performance of the practice in the context of its larger physician organization. Based on the final criteria selected by BCBSM, about a third of nominated specialists received an uplift on select E&M codes in 2013.

Throughout the evolution of PGIP specialty initiatives, MSMS has continued to support the inclusion of specialty societies in the identification of appropriate quality metrics used by BCBSM to determine whether physicians are eligible for the uplifts. MSMS has helped facilitate discussions between specialty society subject matter experts and the BCBSM Clinical Epidemiology and Biostatistics Department responsible for development and measurement of the metrics. These subject matter experts have offered guidance on clinical guidelines, the population to which the metrics should be applied, types of service utilization, and diagnosis or billing codes used in related utilization definitions.
BCBSM has not adopted every metric identified by the respective specialties, but MSMS will continue to advocate that BCBSM continue to reach out to specialty societies pre-metric development and include identified subject matter experts, as well as:

- Meet with specialty societies and their respective members
- Communicate metrics to specialties and physician organizations well in advance of the nomination deadlines
- Improve education and communication on individual physician metrics versus population level performance metrics

This level of commitment and communication remains extremely critical as eligible specialties gain experience in PGIP and as more specialties are included in the uplift process.

In fact, MSMS has been able to advocate successfully for early program changes to make the specialty uplifts more accessible for nominated physicians and to make the nomination easier in general. In 2014, the number of eligible specialties will increase from seven to 24, and by 2015, all specialties except for anesthesiology will be eligible for fee uplifts in PGIP. (BCBSM has indicated that anesthesiologists will not be included at this time because of the manner in which they are reimbursed.)

In addition, BCBSM will increase the proportion of specialists eligible for uplifts and the number of service codes to which the uplifts apply. For each specialty type, BCBSM will choose the top two-thirds of nominated practices to receive fee uplifts, greatly improving the number of physicians who can receive them. Moreover, instead of applying the fee uplifts only to limited E&M codes, specialists can receive a 5-10 percent fee uplift on a broader range of service codes billed to BCBSM.

MSMS also successfully advocated for changes in the requirement for a principal partner nomination for the specialty uplifts. In order for specialists to qualify for a fee uplift, BCBSM previously required nomination from the physician member's physician organization and a principal partner physician organization. Since specialty physicians can affiliate with any physician organization, BCBSM stated the intent of the additional nomination was to ensure the rewarded physicians were those providing a significant amount of patient care. MSMS expressed this additional requirement was too burdensome and was limiting the number of specialists that could participate in the program. As a result, BCBSM will require only a principal partner nomination for nine of the 24 eligible specialties.

The ability of specialists to receive fee uplifts under the PGIP program is a welcome development, but it is still a work in progress, and it is demonstrative of the larger trend in health care toward hybrid fee-for-value physician payment models instead of the strict fee-for-service models of the past. Medicine is entering a new era in which payments will no longer be based on the performance of individual physicians, but rather how well physicians work across specialty and setting to care for attributed patient populations. This is evident in the PGIP physician organization structure, nomination requirements, and the BCBSM metrics designed to measure how efficient physicians are in coordinating care between specialties. MSMS will continue to be the physician's voice and advocate as the details of these new payment models are shaped.

Joe Neller is Director of Integrated Physician Advocacy at MSMS. Stacey Hettiger is Director of Medical and Regulatory Policy at MSMS.
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A Lean, Keen, Problem-solving Machine: 
Doctor Billi’s Dedication Takes Coalition Building & Mentoring to New Levels

By Stacy Sellek

To describe John E. Billi, MD, as perceptive would be a huge understatement. His ability to identify problems in health care, his openness to learning different perspectives, and his willingness to try on different ideas is unique, and— to hear him compare it to nature— nothing short of poetic.

When you are openly receptive to what’s happening in an interactive environment, like nature, your mind is continually exploring everything that you see in a way that is very calming and relaxing. That’s been very psychologically rewarding to me,” says the avid outdoorsman.

Doctor Billi, a New York native who serves as Associate Vice President for Medical Affairs at the University of Michigan Health System, applies that open-mindedness to solving problems in health care.

From a broken window blind in an office to the processes by which health is delivered, no problem is too big or too small. What matters, according to Doctor Billi, is a systematic team approach.

“We have a training program at UM called ‘Physicians as Leaders and Problem Solvers’ in which students and residents learn about different problems, learn scientific problem solving, root cause analysis, and how to construct a plan as an experiment,” explains the professor of Internal Medicine and Medical Education at UM Medical School. “They can apply this process to the problems they’ll face in their practice.”

So what does he personally get out of this? “It’s phenomenal. We are graduating doctors who are empowered to build consensus and help their team solve problems,” says Doctor Billi. “Hopefully they won’t tell people what to do; they will ask thoughtful questions and learn more. I try to model this for them—not to give answers, but drive them to figure it out. When I ask questions, I grow and become a better mentor. It helps me in the work I do at MSMS and beyond.”

‘Coalition work is messy’

Speaking of his work at MSMS, Doctor Billi has no shortage of hats he wears in organized medicine and has not shied away from solving problems in that arena, either. A member of MSMS since 1999, he was involved in health care delivery mostly at UM and in his county. He was invited to a Washtenaw County Medical Society meeting, and began his service on the WCMS Executive Council, then as WCMS President, and then moved on to run for a seat on the MSMS Board of Directors and serve on several MSMS committees.

“Through the MSMS Board, I have found it incredibly valuable to work on various problems and MSMS issues—not just learning about the topics themselves, but what I learned about perspective of other physicians around the state,” he says. “The diversity of backgrounds—that perspective is really valuable.”

He also notes that MSMS offers the opportunity to learn about the areas of payment reform, quality and efficiency, and to learn many different doctors’ perspectives on these.
Doctor Billi firmly believes in trying to understand major trends, influence them positively, and figure out where MSMS could play a role, whether as a leader or through a coalition. This is also how he came to work with the Greater Detroit Area Health Council (GDAHC), eventually winning the Sy Gottlieb Award for Sustained Health Care Leadership from the GDAHC in 2006 for his involvement in its Cost Quality Initiative, which advocates change and improvement in the way health services are delivered, paid for and used within the seven counties of southeast Michigan.

“As I said then, ‘Coalition work is messy,’” he recalls. “If you really want to understand how problems occur across the complex value streams in health care and the perspectives among different groups, you better have them all in the room. If you don’t, it’s too easy to blame those not in the room. It hones our own thinking to have those contributions in real time.”

He also represents MSMS on the Michigan Quality Improvement Consortium (MQIC) and co-chairs the Medical Directors’ Committee. MQIC creates common evidence-based guidelines used by most insurers in the state.

All hands on deck

As a researcher, Doctor Billi’s interests include health services delivery, the cost of medical care, cost reduction education programs, the impact of changing reimbursement systems, and evidence-based guideline uses, to name a few.

When asked if during medical school he saw himself taking on tough topics such as these, he laughs. “No, I saw myself in an academic center, but thought I would be involved in clinical care, teaching, and research,” he admits. “From early on, I found I was a compulsive problem solver.”

Doctor Billi serves as “chief engineer” of the Michigan Quality System, UM Health System’s holistic approach to scientific problem-solving based on lean thinking. The UM team has published results in diverse journals, on topics ranging from radiation oncology to sports medicine to ENT OR turnaround, all examples of using “Lean Thinking (the Toyota Way) in Health Care.”

What could this manufacturing-based improvement model offer health care? “We have 22,000 clinicians, workers, and trainees at UMHS. My goal is to have 22,000 problem solvers,” he says. “Health care workers are surrounded by broken processes; there is enough work for everyone. We need all hands on deck.”

‘The Sheryl Test’

“I can remember in med school where I was studying [State University of New York at Buffalo], it was like I had finally come home,” says Doctor Billi, on how he knew medicine was the right field for him. “I found internal medicine. I was born to be an internist.”

So much so, that he says he is “honored” to be able to still see patients one day a week. “If I didn’t practice, I wouldn’t have that first-hand experience and insight,” Doctor Billi explains. “It is a weekly reminder for me about why I’m here. I take my turn on the front line so I can help my patients and more deeply understand challenges of health care delivery. That’s what keeps me going. It’s not time to quit working yet. There’s still more to do.”

He also relies on the valuable feedback he gets from his wife, Sheryl Hirsch, MD, a Novi pediatrician whom he met while they both attended SUNY Buffalo.

WHAT WOULD DOCTOR BILLI ADVISE COLLEAGUES WHO WANT TO AFFECT CHANGE IN HEALTH CARE?

- Listen much more than you speak to learn perspectives, seek them out.
- Look for opportunities to go into the community or meet with business leaders, hospital leaders, nursing leaders, health plan leaders – broaden your contacts.
- Go and see, ask why and respect people, to learn what problems look like for yourself.
- Show up. I know physicians are busy, but participating is really important. Show the respect to be where you are supposed to be. Participate actively and do your homework.
- Grab hold of an opportunity, find a problem, and try to fix it.

“I have what I call ‘The Sheryl Test.’ I routinely bounce ideas off her – she’s been in practice for 32 years and will tell me what she really thinks of the idea,” he shares. “She’s been my strongest supporter and inspiration.”

Not only do Doctor Billi and his wife work in health care, but their son (an aspiring lean practitioner) works for Blue Cross Blue Shield of Michigan on the Physician Group Incentive Program, and their daughter (also a fan of lean) is working toward her MD and received her PhD in human genetics at UM in the Medical Scientist Training Program.

When he is able to carve out free time, Doctor Billi enjoys fly fishing, cross country skiing, bike riding, spending time in the woods or on a river – out in nature, which he refers to as “the most precious time.”

After all, that interaction with nature is what he says reminds him to retain an open mind in everything he does, including – and perhaps especially – solving problems in health care. 

The author is senior manager of communications at MSMS.
What to Tell Your Patients About Electronic Health Records

You've taken the plunge into the world of health information technology (HIT). After months of preparation and planning, vendor demonstrations and selection, workflow assessments, staff training, and implementation, your electronic health record (EHR) system is now live. Physicians and staff alike are invested in making HIT work and achieving the ideals of improved efficiency, quality and coordination of care, and safety. But what about your patients?

Many patients may not understand why you've chosen to move from a paper environment to an electronic environment and how that decision may impact them. Others may be concerned about the security of their medical records. They may not know what an EHR does or how it differs from an electronic medical record or personal health record. Patients need to be included in the conversation about HIT, the impact on care delivery as HIT is implemented into practice, reasonable expectations, and self-management opportunities.

Patients view physicians as the most trusted source of health care information. It is likely that they will look to you to answer their HIT questions, as well. The Office of the National Coordinator for Health Information Technology (ONC) developed a fact sheet about how to talk to patients about electronic health records. Below are some questions compiled by the ONC and other sources that you might receive from your patients as well as suggestions on how you might answer them.

**What is HIT?**
The software and infrastructure used in the clinical practice of medicine to support documentation, storage and exchange of patient data. Examples include EHRs, ePrescribing and computerized physician order entry (CPOE).

**Why Electronic Health Records?**
Electronic health records or “EHRs” make it possible for your health care providers to better manage your care through secure use and sharing of health information.

Electronic health records are similar to electronic medical records, which are a digital version of the paper charts in a health care provider’s office. However, electronic health records are built to share information with other health care providers, such as laboratories and specialists, so they contain information from all the clinicians involved in your care.

With electronic health records, your complete health care information can be accessed by your health care providers in a secure and timely manner.

**What Is an Electronic Health Record?**

An electronic health record is not just a computerized version of your paper chart. It’s a digital record of your health information that can provide your care team with comprehensive health information about you. Over time, it can allow your providers to share important information, across different health care settings, in accordance with federal and state privacy and security requirements.

This is one of the key features of an EHR: It is designed to allow appropriate information sharing beyond the health care provider who first collects the information.

It is built to share information with other providers, such as labs and specialists. It can contain information from all the providers involved in your care in a practice setting, or it can link through secure information networks to information held in other providers’ EHR systems. And, as health information exchange capabilities advance further, the information can move with you – to the specialist, the hospital, the nursing home, the next state, or even across the country.

**What’s the Difference between Electronic Health Records and Personal Health Records?**

Information in an electronic health record is typically entered by and accessed by your health care providers. A personal health record is designed to be set up and accessed by patients themselves.

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- Connect and collaborate with other MSMS members about EHR and IT and referrals

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Docright’s web-based service empowers physicians and their staffs to make faster, more informed decisions about EHR and IT vendors and their products and services. By optimizing the use of EHR and IT, Docright can increase practice revenues, reduce costs, and improve health care. Docright also enables physicians and their staffs to more easily connect with each other through referrals and recommendations and by sharing information focused on optimizing clinical and business outcomes with EHR and IT.
What Advantages Do Electronic Health Records and Personal Health Records Offer?

They can help you:
• Become more actively engaged in your own care
• Take care of your family members more easily

Having a system in place to help you track and access health information for you and your family can help you prevent and manage illness.

How Else Can an Electronic Health Record Help Me?

Storing health information in an EHR has potential benefits for you as well as for your health care providers. Benefits to you include:
Better care. With an EHR, all of your health information can be in one place. A networked EHR system can give providers more accurate and complete information about your health, so you receive the best possible care.
Better care coordination. Having information in electronic form means that it can be shared easily with the people who ensure that you are receiving the care you need. Because providers have the ability to share information with other providers involved in your care, the care you and your family receive is better coordinated.

More involvement in your care. You can fully take part in decisions about your health and those that you are caring for. By making all your health care providers aware that you have an EHR, they will be able to securely share information with you electronically (e.g., through a personal health record).

How is my Health Information Protected?

Privacy and security safeguards are in place to protect your personal health information. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, a federal law, requires your health care providers to give you a Notice of Privacy Practices to inform you how your information may be used and shared, as well as how you can exercise your rights under the HIPAA Privacy Rule. The same privacy rules that protect your paper records also protect your EHR.

In addition, the HIPAA Security Rule, also a federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. Standards include access controls, like tracking who can access your health information and password protections.

With EHRs, in fact, there are additional security features like passwords and digital fingerprints to safeguard your information.

Patients interested in learning more about HIT can be directed to ONC’s Website at www.HealthIT.gov. The ONC has produced several resources for patients including a short video, Health IT for You – Giving You Access to Your Medical Records, that addresses the evolution in an easy-to-understand format. The video can be accessed at www.healthit.gov/patients-families/video/health-it-you-giving-you-access-your-medical-records.

The Patient Centered Medical Home: Coordinated Care, Optimal Outcomes
Date: Tuesday, October 22, 2013
Time: 9:00 a.m. to 4:15 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, administrators, office managers, and all other health care professionals

Symposium on Retirement Planning
Date: Wednesday, October 23
Time: 5:45 p.m. to 8:15 p.m.
Location: Somerset Inn, Troy
Contact: Caryl Markzon (517) 336-7575 or cmarkzon@msms.org
Note: Dinner will be provided
Intended for: Retired physicians, and physicians planning for retirement, spouses and office managers

148th Annual Scientific Meeting
Date: Wednesday, October 23 through Saturday, October 26
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: Affordable Care Act
Date: Thursday, October 24, 2013
Time: 8:30 a.m. to Noon
Location: Somerset Inn, Troy
Contact: Caryl Markzon (517) 336-7575 or cmarkzon@msms.org
Intended for: Physicians, executives, office administrators/managers, and all other health care professionals

ER/LA Opioid REMS: Achieving Safe Use While Improving Patients Care – FREE
Date: Thursday, October 24, 2013
Time: 5:45 p.m. to 8:15 p.m. (dinner included)
Date: Friday, October 25, 2013
Time: 8:30 a.m. to Noon
Location: Somerset Inn, Troy
Contact: Marianne Ben Hamza, (517) 336-7581 or mbenhamza@msms.org
Intended for: Physicians and all other health care professionals

Payment Reform: Advancing Quality and Affordability
Date: Wednesday, January 29, 2014
Time: 9:00 a.m. to 3:30 p.m.
Date: Wednesday, March 26, 2014
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

To Register Online: www.msms.org/eo
Mail registration form to: MSMS Foundation
PO Box 950, East Lansing, MI 48826-0950
Fax Registration form to: 517-336-5797
Phone MSMS Registrar at: 517-336-5781

Jeffrey J. Kimpson, M.D., D.A.A.P.M.
Medical Director, Providence Pain Management Center
Board Certified in Anesthesia and Pain Medicine

John H. Traylor, M.D., D.A.A.P.M.
Director of Clinical Services
Board Certified in Anesthesia and Pain Medicine

Jeffrey J. Kirouc, M.D.
Member, American Pain Society
Member, American Academy of Pain Management

Dominick Lago, M.D.
Member, American Pain Society
Member, American Academy of Pain Management

Alexander Ajlouni, M.D.
Member, American Pain Society
Member, American Academy of Pain Management

Affiliated with Northland Anesthesia Associates, P.C.
What’s in a Name?  
By Cindy Ackerman

As part of the MSMS Alliance’s reorganization, the Alliance was asked to store more than 20 boxes stored at MSMS’s off-site facility. Without a better alternative, I took the boxes home with me, and so I got busy trying to combine the contents and minimize the volume. At first it seemed a daunting chore, but as I got underway, I was delighted to learn more about this remarkable organization we call the MSMS Alliance.

The Alliance started with one woman. College-educated in the 1800s, Caroline Bartlett was an activist and a practicing minister when she married Doctor Warren Crane in 1896 in Kalamazoo. When she retired, she had the idea to establish the “Women’s Auxiliary of the Michigan State Medical Society.” Her mission: to improve public health and safety and support physicians in their efforts to provide excellent patient care. She presented her idea at the MSMS Annual Meeting on Mackinac Island in 1926.

One of the organization’s earliest projects was to sponsor homecare nursing courses to encourage women to enter the nursing profession. Other activities included assisting the Red Cross, conducting first aid classes and volunteering in hospitals. In the 1950s, the Auxiliary lobbied against socialized medicine. In the 1960s, we fought for stricter penalties for drug dealers and helped MSMS make sex education part of school curriculums.

In the 1970s, the Women’s Auxiliary of MSMS changed its name to the MSMS Auxiliary.

In the 1980s, Auxiliary members were placed on MSMS committees and were included in legislative strategies.

In the 1990s, while tackling issues such as gun safety, medical liability, domestic violence, volunteerism, and binge drinking, the MSMS Auxiliary once again changed its name to the MSMS Alliance to reflect the true partnership between the organizations.

In 2002, MSMS Immediate Past President Billy Ben Baumann, MD, dedicated the Alliance Conference Room at the MSMS building.

Today, the MSMS Alliance’s tradition of advocating for issues important to patients and physicians remains our focus. Annually, we partner with the MSMS Foundation on Doctors and Their Families Make a Difference Day and we bring awareness to domestic abuse with our SAVE Day events. We are also proud of our legislative contributions on behalf of MSMS.

This year, the Alliance will continue our mission to support MSMS and strengthen our partnership. In addition to our annual events, we have plans to visit Lansing to engage legislators in conversations over the Patient’s Right to Know and nurse scope expansion bills. The Alliance will focus on educating young parents on the benefits of childhood immunization.

This opportunity to get to know the Alliance on a more intimate level, has given me a deeper understanding and appreciation for the women and men who made and continue to make a difference in our communities, no matter what we’re called.

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
Influenza season is fast approaching, and the Michigan Department of Community Health (MDCH) needs your help! The Outpatient Influenza-like Illness Surveillance Network (ILINet) is an integral part of influenza surveillance in Michigan. ILINet consists of frontline health care providers who voluntarily provide weekly counts of patient visits for influenza-like illness (defined as fever ≥100° plus cough and/or sore throat) to MDCH and CDC. Effective influenza surveillance helps inform state and local public health when influenza activity begins, peaks, and ends in their area; detect new or unusual influenza virus strains; and assess the effectiveness of influenza control programs.

In appreciation of their efforts, sentinels receive free laboratory testing for approximately 11 specimens per season; weekly feedback reports including summaries of regional, state, and national influenza data; and free online subscriptions to Emerging Infectious Diseases and CDC’s Morbidity and Mortality Weekly Report. Sentinels who regularly report throughout the flu season also will receive free registration the following fall to an MDCH Fall Regional Immunization Conference for two staff.

Volunteering to be a sentinel should require less than 30 minutes per week. We are asking medical providers of any specialty (e.g., family medicine, internal medicine, pediatrics, infectious disease) in nearly any setting (e.g., private practice, public health clinic, urgent care center, emergency room, university student health center) who are likely to see patients with influenza-like illness to consider becoming an influenza sentinel. Only those physicians/providers who primarily care for institutionalized populations (e.g., nursing homes or prisons) are ineligible.

To enroll or for more information, contact Stefanie DeVita, RN, MPH, Influenza Epidemiologist at MDCH Division of Immunization, at DeVitaS1@michigan.gov or 517-335-3385.

HPV Vaccine: Safe, Effective, and Grossly Underutilized

A new study looking at the prevalence of human papillomavirus (HPV) infections in girls and women before and after the introduction of the HPV vaccine shows a significant reduction in vaccine-type HPV in US teens. The study, published in the June issue of The Journal of Infectious Diseases, reveals that since the vaccine was introduced in 2006, vaccine-type HPV prevalence decreased 56 percent among female teenagers 14-19 years of age.

“This report shows that HPV vaccine works well, and the report should be a wake-up call to our nation to protect the next generation by increasing HPV vaccination rates,” said CDC Director Tom Frieden, MD, MPH. “Unfortunately, only one third of girls aged 13-17 have...
been fully vaccinated with HPV vaccine. Countries such as Rwanda have vaccinated more than 80 percent of their teen girls. Our low vaccination rates represent 50,000 preventable tragedies – 50,000 girls alive today will develop cervical cancer over their lifetime, which would have been prevented if we reached 80 percent vaccination rates. For every year we delay in doing so, another 4,400 girls will develop cervical cancer in their lifetimes.”

Despite the effectiveness of HPV vaccine, new data from the National Immunization Survey for Teens (NIS-Teen) shows that HPV vaccination rates among females remain unchanged from 2011 to 2012. The 2012 NIS-Teen data show that not receiving a health care provider’s recommendation for HPV vaccine was one of the five main reasons parents reported for not vaccinating daughters. Health care providers are urged to give a strong recommendation for HPV vaccination for boys and girls aged 11 or 12 years.

The other responses parents provided indicate gaps in understanding about the vaccine, including why vaccination is recommended at ages 11 or 12. Parents need reassurance that HPV vaccine is recommended at 11 or 12 because it should be given well in advance of any sexual activity. Take the time to talk to parents of preteens in your office and answer any questions they may have. HPV vaccine is safe and effective, and unfortunately, grossly underutilized.

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**Alarming HPV Vaccination Rates**

- **53.8%** of US females 13-17 years of age have received one or more doses of HPV vaccine
  - In Michigan, 50.45% of females 13-17 years of age have received one or more doses of HPV vaccine*

- **33.4%** of US females 13-17 years of age have received three or more doses of HPV vaccine
  - In Michigan, 29.71% of females 13-17 years of age have received three or more doses of HPV vaccine*

- **84%** of unvaccinated girls had one or more missed opportunities for HPV vaccination

- Potential coverage with one or more doses of HPV vaccine could be 92.6% if there were no missed opportunities for vaccination

*Data from the Michigan Care Improvement Registry as of August, 2013

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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: 6-24-2013 through 6-28-2013
Faith Abbott, DO, PT
Saginaw, MI
51-01-011271
55-01-002390
06/24/2013
Probation, Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements
John Charles Mitchell, DO
Sanctuary, MI
51-01-013191
06/25/2013
Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements
Larry C. White, DO
Romeo, MI
51-01-006210
06/17/2013
Reclassified – On Part Controlled Substance
Limitation – Remains in Effect – 2 yrs.
Probation – Concurrent w/Limited/Restricted
Report Dated: 7-8-2013 through 7-12-2013
Stephen Boskenberry, MD
Ada, MI
43-01-087079
07/14/2013
Summary Suspension
Failure to Report/Comply
Criminal Conviction
Charles Allen Davis, MD
Waterford, MI
43-01-038223
08/01/2013
Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements
Marian H. Awada, MD
Southfield, MI
43-01-082433
07/17/2013
Fine Imposed
Violation of General Duty/Negligence
Joel Imperial De Guzman, MD
Clinton Township, MI
43-01-091071
07/17/2013
Suspension
Negligence – Incompetence
Edward Lamar Harwell, MD
Cadillac, MI
43-01-025505
07/17/2013
Suspension
Violation of General Duty/Negligence
Carlotta Maria Maresca, MD
Saginaw, MI
43-01-042961
07/17/2013
Reprimanded
Violation of General Duty/Negligence
Grecie Gregory Miklashek, MD
Kalamazoo, MI
43-01-061219
07/17/2013
Voluntarily Surrendered
Negligence – Incompetence
Melvin Columbus Murphy, MD
Southfield, MI
43-01-041189
07/17/2013
Fine Imposed
Violation of General Duty/Negligence
Michele Renee Ritter, MD
Pontiac, MI
43-01-070661
07/17/2013
Fine Imposed
Violation of General Duty/Negligence
Seymour N. Cywiak, DO
Ann Arbor, MI
43-01-075134
08/16/2013
Voluntarily Surrendered
Violation of General Duty/Negligence
Margy Temponeiras, MD
Portsmouth, OH
43-01-066792
08/16/2013
Reprimanded
Violation of General Duty/Negligence
Louis Edwin Wulfekuhler, MD
Lansing, MI
43-01-085580
08/16/2013
Probation Limited/Restricted
Suspension
Dana Sue Kraker, DO
Holland, MI
51-01-011073
07/15/2013
Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements
Paul Randal Miluk, DO
Niles, MI
51-01-010370
07/20/2013
Summary Suspension
Lack of Good Moral Character, Drug Diversion, Violation of General Duty/Negligence
Sister Marysa Weber, DO
Alma, MI
51-01-086897
07/11/2013
Probation, Reprimanded, Fine Imposed
Failure to Meet Cont. Ed. Requirements
Report Dated: 7-22-2013 through 7-26-2013
Rosanne Murphy, MD
Birmingham, MI
43-01-050350
07/29/2013
Summary Suspension
Mental/Physical Inability to Practice
Violation of General Duty/Negligence
Sister Marysa Weber, DO
Alma, MI
51-01-086897
07/11/2013
Probation, Reprimanded, Fine Imposed
Failure to Meet Cont. Ed. Requirements
James Patrick LaBerge, DO
Okemos, MI
51-01-010031
08/31/2013
Fine Imposed, Probation
Mental/Physical Inability to Practice
Violation of General Duty/Negligence
Sister Marysa Weber, DO
Alma, MI
51-01-086897
07/11/2013
Probation, Reprimanded, Fine Imposed
Failure to Meet Cont. Ed. Requirements
Jill Elizabeth Sol-Friedman, DO
Farmington Hills, MI
51-01-011882
09/05/2013
Failure Imposed, Reprimanded
Violation of General Duty/Negligence
Farmington Hills, MI
51-01-011882
09/05/2013
Failure Imposed, Reprimanded
Violation of General Duty/Negligence
Clarkston, MI
52-01-007975
09/15/2013
Suspended
Failure to Report/Comply
Sister State Disciplinary Action
Debra Kay Roggow, DO, RN
Lansing, MI
51-01-010386
47-04-105205
09/15/2013
Suspended
Failure to Report/Comply
Sister State Disciplinary Action
Francis F. Whitlow, DO
Stanton, MI
51-01-005235
09/15/2013
Suspended
Failure to Meet Cont. Ed. Requirements
Report Dated: 8-26-2013 through 8-30-2013
Norman Theodore Samet, MD
Novi, MI
43-01-023831
08/29/2013
Probation, Reprimanded, Fine Imposed
Failure to Meet Cont. Ed. Requirements
Robert Martin, DO
Milford, MI
51-01-007975
08/30/2013
Summary Suspension
Failure to Meet Cont. Ed. Requirements
Substance Abuse
Violation of General Duty/Negligence
Mental/Physical Inability to Practice
Notice of Intent to Deny – formal document that indicates the Department intends to deny the issuance of a license because of violations of the Public Health Code, past or current.
Probation – a disciplinary action in which the licensee’s practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:
- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.
Reinstate – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.
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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- Provides strategic direction for the clinical quality performance measurement system

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Office Procedures in Primary Care

Wednesday, October 30, 2013 • 7:30 a.m. – 4:00 p.m.

COURSE DIRECTOR
Barry J. Scofield, MD
St. John Hospital and Medical Center, Detroit, MI

SYMPOSIUM

Overview on Family Medicine Residency Policies on Learning Office Procedures
Mark R. Paschall, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

Cosmetic Office Procedures in Primary Care
Jeffrey L. Williams, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

GYN Office Procedures
Anne M. Schneider, MD
Assistant Clinical Professor, Wayne State University; Staff Physician, St. John Hospital and Medical Center, Detroit, MI

Office Based Ultrasound Procedures
Leonard V. Bunting, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

General Derm Office Procedures
Kwame O. Francis, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

Ankle-Brachial Index
Randall Colvin, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

The New “Accountable Care Organizations” and How They May Affect Primary Care
Kenneth W. Bollin, MD
Chief, Family Medicine Department, St. John Hospital and Medical Center, Detroit, MI

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This symposium will be held at the Grosse Pointe War Memorial
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Interested individuals should submit a statement of interest and curriculum vitae via mail or email by October 31, 2013 to:

Jim Aldrich
Medical Staff Office
36475 Five Mile Road, Livonia, MI 48154
aldrichj@trinity-health.org

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The future of medical practice is a top concern for us as members of the medical society. One area that receives too little discussion, though, literally is the future of medical practice – physician education. There is growing discussion about how both undergraduate and graduate medical training needs to change to stay ahead of evolving health care demands. Some of the proposed changes are necessary. Some, however, may bring unintended consequences.

Change is definitely in the air. The American Medical Association has announced an $11 million “Accelerating Change in Medical Education” initiative to fund innovative projects at medical schools (including $1 million to the University of Michigan). The goal is to fund model projects that bring medical education curricula closer to 21st century medical practice, improve continuing education skills, and shape new measures for learning. The University of Michigan grant, for example, will expose undergrads to the university’s clinical settings earlier in their training, and help establish an “M Home” learning community to support the student throughout his or her medical school career.

No doubt our undergraduate and graduate physician training needs some updates. The undergraduate education process has lengthened considerably over the years. One result – the average age of physicians entering practice has climbed, with the percentage of new physicians under 35 dropping by half over the past couple of decades. Skills such as leadership and ability to work well in team care settings are crucial in an era of health care reform, and it’s good to see changes underway in medical school curricula. Our training has assumed the lone practitioner rules the health care universe, but care teams, more efficient and cost-effective, are fast becoming the standard health care model.

We also need to focus on teaching our young physicians how to communicate. A broad range of communication skills are crucial for physician effectiveness. We must be able to communicate well with our patients, both in active listening and in sharing our counsel (how else can we encourage them not to smoke, exercise, deal with obesity, and attend to chronic illnesses?). But tomorrow’s physicians must also be able to communicate to patients and to our communities the value of the care they offer. Physicians too often leave medical school with a “coronation” mentality, rather than realizing that we must now “sell” society on the idea that the cost of good health care is worth the investment.

Our medical school graduates need to know how to communicate, how to advocate, and how to lead. Other professions place a much higher priority on those skill sets. They understand its value, its power, and the importance of the ability to persuade. Maybe we need to put more weight on an applicant’s leadership and communication skills for admission to medical school. I fear that the medical profession has become complacent, too fat and sassy, and our leadership role in health care may become a fleeting memory without a stronger emphasis on these skills.

The value of some medical education reforms is less certain. As I noted above, the time required for a medical degree is lengthening, so curriculum changes to shorten the program are being discussed. It’s also assumed fewer years in medical school would help lighten the scary level of student loans demanded today. But many of the “softer skills” noted above, like leadership, teamwork and communication, need added time to develop, and are just the items that would be lost if we cut training to the “necessities.” A shorter medical school course could also have unintended consequences. For example, we’ve seen how limiting residents’ work hours has lessened exhaustion – but it also reduces residents’ clinical experience and weakens patients’ continuity of care.

Do we need to shake up how we deliver undergraduate medical education in America? Yes. Do we need to use care in doing so? An even louder YES!
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