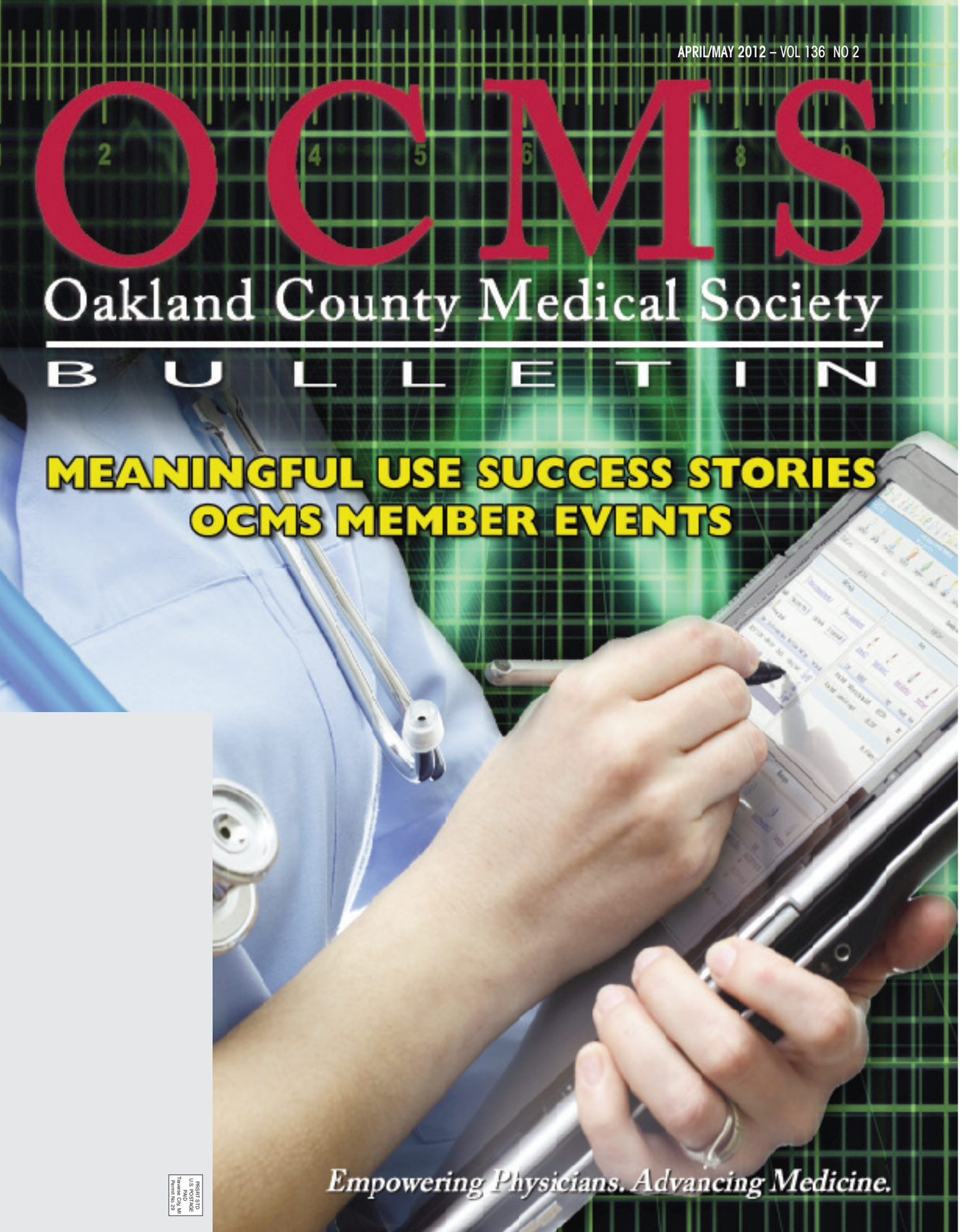
APRIL/MAY 2012 – VOL 136 NO 2

OCMS

Oakland County Medical Society

BULLETIN



MEANINGFUL USE SUCCESS STORIES
OCMS MEMBER EVENTS

Empowering Physicians. Advancing Medicine.

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Authoritative records of the Oakland County Medical Society are to be found in the minutes of the meetings, which are filed with the office of the Society.

Statements and opinions expressed in articles published in the *BULLETIN* are those of the authors and not necessarily those of the Oakland County Medical Society. Advertisements do not represent approval or recommendation of the Oakland County Medical Society.

All communications relative to articles and advertising should be addressed to The Editor, Oakland County Medical Society, 41800 W. 11 Mile Road, Suite 215, Novi, MI 48375; (248) 773-4000, Fax (248) 773-4004.

VOL 136 NO 2

OCMS
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BULLETIN

APRIL/MAY 2012

FEATURES

OUR PURPOSE
Oakland County Medical Society advocates for, informs and empowers physicians so they can focus on providing the best quality patient care now and in the future.

OUR MISSION
To grow Oakland County's community of actively involved physicians served by an organization positively impacting their work environment to improve the practice of medicine.

OUR VISION
By improving health care delivery and consequent health, we improve the quality of life in Oakland County.

AN ERA OF CHANGE

BY BARRY AUSTER, MD
OCMS President

This past September 19th, the Obama administration submitted to Congress a plan to save the federal government $4 trillion over the next decade. This included $320 billion in cuts to Medicare, Medicaid and other federal health care programs. According to administration officials, 90% of the savings would come by reducing "overpayments" to providers and drug companies. The proposal would increase the power of the IPAB (Independent Payment Advisory Board) by reducing the target percentage whereby they are able to make recommendations for cuts from 1% to 0.5%. The proposal also affects what beneficiaries pay for the program. Beginning in 2017, based on income, it is estimated that 25% of beneficiaries will be subject to increases in their Medicare Part B and D by 15%. One ray of hope for physicians is that the proposal assumes that Congress will end the SGR formula which was on schedule to reduce payments to physicians by 30% by the end of February. Unfortunately this did not happen and instead Congress voted for a 10-month patch in 2012.

One significant aspect of the above proposal is to allow the IPAB to use a "value-based benefit design." This item is at the heart of the PPACA (Patient Protection and Affordable Care Act). This is basically the pay-for-performance concept by which CMS intends to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care. Section 3007 of the Affordable Care Act mandates that by 2015, CMS begin to apply a value-based payment modifier under the Medicare Physician Fee Scheduler (MPFS). The four following points are key for physicians to be aware of: Both cost and quality data will be used to calculate payments for physicians, doctors will be compared to their peers, every payment will be adjusted up or down based on the single modifier that CMS chooses for a practice and payment will not be a flat rate but a 1% or 2% change in payment. This system will go into effect for some medical practices by 2015 but by 2017 every provider will be subject to the value-based payment modifier. The key point here is that the measurement year for the value-based modifier is 2013. In addition, this data will be available for the public at www.medicare.gov. For the past few years CMS has been experimenting with quality reporting via the PQRS program. This therefore is a good way for physicians to prepare for the future programs.

Clearly we are living in an era of change for doctors. For some physicians who feel that they cannot adapt it may lead to early retirement or leaving private practice. Some are banking on the repeal of the PPACA if President Obama is defeated in November. However, most authorities feel that even if there is a change in the administration, much of the PPACA will be retained.

There is simply too much momentum going forward. Our best course of action is to remain as involved in the process as possible, and it is making a difference. The ACO concept is still evolving with our input –for example, the quality metrics have been reduced from 65 to 33. In addition, the application process to join an ACO has changed to more of a rolling process to allow practices more time to prepare and join. ICD-10 implementation has been delayed and CMS continues to seek out organized medicine's concerns on this system. And while certainly not in the ideal manner, the Medicare payment cuts scheduled to happen on March 1 were stopped for the time being. I would therefore implore you to continue your support of the state and county medical societies and to heed our calls for contacting your state and national legislators when important issues arise.

WHEN YOUR PATIENT BRINGS BACK MORE THAN SOUVENIRS

By PAMELA B. HACKERT, MD, MPH, JD
Chief of Medical Services, Oakland County Health Division

The 2009 H1N1 Flu catapulted international infectious disease concerns into the mainstream. Almost overnight, or at least over spring break, preschool children were coughing into their sleeves, elementary school children were washing their hands, parents were discussing where to get flu shots and doctors were signing up for ProMED-mail. (http://www.promedmail.org) I created my first Twitter account so I could follow developments as they were tweeted by the CDC! And although international travel continues to increase, Oakland County residents have been bringing home more than souvenirs for many years.

The most common complaints in returned travelers are diarrhea, respiratory tract illness, skin conditions, and fever. Most of these commonly encountered bacterial and viral infections have short incubation periods and will have their onset either abroad or within the first week or two of return. These are the cases that create the stories told by travelers to friends and family, but may never be seen in your office. However, diseases such viral hepatitis, malaria, and tuberculosis have longer incubation periods and may present weeks to months after returning home.

In the chart below are the year-end totals for some of the diseases that OCHD has investigated over the past 10 years that were acquired from travel abroad.

Running down the list for a bit more information on cases that we have seen in Oakland County, Nontyphoidal Salmonella is, of course, most often acquired here, but a significant percentage—about 14% nationally, is picked up during foreign travel. It usually causes mild and self-limiting diarrhea which is over in about 5-7 days. Recently, however, there is increasing Ciprofloxacin resistance documented, particularly in Egypt, Spain and Thailand, and travelers returning from these countries with complaints of prolonged diarrhea an alternative medication might be considered. Not surprisingly, Shigella is also a common cause of traveler's diarrhea when considering that as few as 10 organisms are sufficient to cause infection. Transmission occurs via the fecal-oral route, and travelers are often infected indirectly through contaminated food or water. Even flies can contaminate food! Again, usually the diarrhea is mild but severe infections can occur with toxemia, vomiting, tenesmus, postinfectious arthritis, hemolytic uremic syndrome (after infection with Shiga toxin–producing strains), or seizures (young children). Multidrug resistance among Shigella strains is common, but resistance to fluoroquinolones is rare and has mainly been seen in south Asia. Therefore, in the United States, empiric treatment should begin with a fluoroquinolone or azithromycin until information about antimicrobial susceptibility is available.

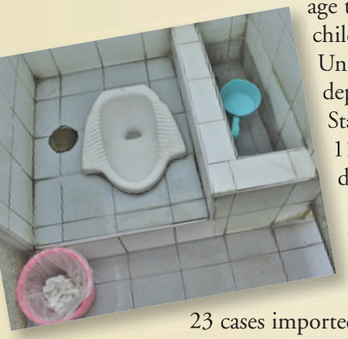
Import Associated Cases	YEAR END TOTAL CASES 2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2002-2011 Mean
Salmonellosis*	N/A	N/A	N/A	15%	8%	14%	19%	7%	12%	12%	12%
Shigellosis*	N/A	N/A	N/A	44%	36%	22%	31%	29%	28%	7%	26%
Typhoid Fever	4	3	3	2	1	3	2	3	3	2	3
Measles	0	0	0	0	0	1	0	0	0	2	0
Mumps	1	3	0	5	7	1	1	0	8	4	3
Dengue Fever	1	1	0	0	1	2	3	1	1	0	1
Malaria	8	7	5	3	1	3	4	6	3	7	5

**Presented as percent of annual case count that was internationally travel associated. Travel data not available prior to 2005.*

CommunityHealth

In the past two years, there have been five cases of typhoid fever (Salmonella typhi) in Oakland County, all of which were acquired during travel abroad to visit friends and family. With our diverse population, OCHD has seen about three cases a year during the last decade. Typhoid is a significant public health threat because of the extensive ramifications that arise if the cases or contacts are food service employees, in daycare, or any place where there may be fecal-oral transmission to a large number of contacts. OCHD epidemiologists work closely with both patients and employers to ensure that exclusions or restrictions from work or day care do not place undue burden on the patients or household contacts but that the public health is protected.

While the CDC recommends typhoid vaccine for travelers to areas where there is an increased risk of exposure to S.Typhi, in the past year Oakland County has also had cases of traditional vaccine preventable diseases, namely measles and mumps. Measles has been particularly concerning because in the nine years prior to 2011, there had been only one case in our county. In 2011 there were two cases and there has already been a case in 2012. With so many parts of the world, including Europe, experiencing an extensive outbreak, Oakland County residents can be exposed not only through their own travel, but through contact with visitors or returning friends and family. Although early symptoms of measles resemble a mild cold, measles is among the most contagious diseases, with the virus remaining active and contagious for up to 2 hours in the air or on surfaces. Particularly for international travelers, the risk for measles exposure is high and vaccination prior to travel is critical. Additionally, children who travel or live abroad should be vaccinated at an earlier age than that recommended for children who reside in the United States. Before their departure from the United States, children age 6 through 11 months should receive 1 dose of MMR.



A more exotic disease that we consistently see in Oakland County is malaria. Since 2007, there have been 23 cases imported into the county, with seven in 2011 alone! Following the national pattern, most of our cases have been travelers to sub-Saharan Africa. Antimalarial drugs taken for prophylaxis by travelers can delay the appearance of malaria symptoms by weeks or months, long after the traveler has returned home, which is why it is so critical to ask about travel in the past 12 months. One of our cases had diligently taken their anti-malaria medications, but having finished one drug after leaving the malaria area, he did not finish taking the other medication. Even with perfect adherence to taking medications, these regimens are not 100% effective and clinical suspicion must remain high for this disease. A common factor contributing to death from malaria is the failure of the physician to consider the diagnosis early in the course of the disease. Persons who present with fever who have visited regions in which malaria is endemic should be evaluated with thick and thin blood smears and if negative these should be repeated every 12-24 hours for a total of three sets. In addition to microscopy, other laboratory diagnostic tests are available. The antigen detection test can rapidly determine that the patient is infected with malaria, but cannot confirm the species of parasite.

Although the brief discussion above did not include the cases of Dengue Fever, Brucellosis, or Hepatitis E seen in Oakland County in the past decade, it is clear that a person with almost any disease can walk through the door of your office here in Oakland County. Oakland County Health Division Communicable Disease Unit (OCHD-CDU) can help facilitate contact investigations, lab sample transportation in cases where the sample must go to MDCH or the CDC, and work with your patient and their family to ensure the safety of their community. The OCHD-CDU department website is www.oakgov.com/health/program_service/epi_unit.html with phone and address:

Main Phone: 248-858-1286
After Hours Emergency Phone: call 248-858-0931
(Ask for the health administrator on call)
Fax: 248-858-0178
1200 N. Telegraph Rd. Bldg. 34E
Pontiac, MI 48341-0432

MSMS News

Leadership for Physicians, Advocacy for Patients

SAVE THE DATE FOR THE MSMS FOUNDATION GOLF & TENNIS CLASSIC

Monday, May 14, 2012
Walnut Hills Country Club, East Lansing

It's not too soon to reserve your spot for the Monday, May 14, 2012 MSMS Foundation Golf & Tennis Classic. Don't miss the relaxing fun of a day on the course with friends (or play tennis if you prefer) followed by an abundant Afterglow party and silent auction at a new venue for us, the beautiful Walnut Hills Country Club in East Lansing. Proceeds support MSMS Foundation grants to community-based health projects across Michigan, and also the Kevin A. Kelly Leadership Fund to provide training for emerging physician leaders. Twosomes, foursomes and individuals are welcome for golf or tennis-we're glad to make pairings! Remember, a portion of your registration fee is tax-deductible. Questions? Contact Sheri Greenhoe, Executive Director, MSMS Foundation at sgreenhoe@msms.org or 517-336-7603.

NEW

MSMS FOUNDATION SPRING SCIENTIFIC MEETING

Thursday, May 17th & Friday, May 18th
Eagle Crest Resort, Ypsilanti

Please join the Michigan State Medical Society Foundation at its first Spring Scientific Meeting (SSM). Located near Ann Arbor in Ypsilanti, there will be many "family friendly" area activities for your guests to enjoy while you to collaborate with colleagues, discover the latest our medical industry vendors offer, and learn about the cutting-edge clinical advances from local and national experts.
For additional information, please contact Marianne Ben Hamza at (517) 336-7581 or mbenhamza@msms.org.

House of Delegates

The 147th annual MSMS House of Delegates meeting will take place Friday, April 27th through Sunday, April 29th, at The Henry, Dearborn.

Last year, more than 300 physician leaders, delegates, and alternate delegates turned out to make policy in Michigan during the 146th annual MSMS House of Delegates meeting in Kalamazoo. Delegates and alternates considered over 80 resolutions on a host of topics that included the safety of electronic medical records, pertussis vaccination, medical marijuana, hazards of energy drinks, retroactive recovery of funds, cell phone ban while driving, and vision screening for children.

The OCMS Delegation Committee has already submitted resolutions for consideration by the entire MSMS delegation in April. Some resolutions submitted last year by OCMS' 41-member delegation pertained to revision of the retired and life member categories, bath salt ban, accountability of repricing networks and water fluoridation. For more information about the MSMS House of Delegates, visit www.msms.org/hod.

Meaningful Use Success Stories

OCMS would like to applaud the efforts and share the stories of two solo practice physicians that were successful in achieving the first stage of Meaningful Use.

Q&A

THOMAS M. FLAKE, JR., MD

Doctor Flake is a general surgeon specializing in breast surgery with offices in Southfield.

Left – Thomas M. Flake, Jr., MD
Above – Doctor Flake's office staff, Russ Mathis, Heidi Simonato, RN, and Jason Flake standing in front of a poster in their office signed by breast cancer survivors.

HOW DID YOU PICK YOUR EMR SYSTEM?

Our office wanted to go paperless so we started looking around and the Detroit Medical Center seemed to be years ahead of everyone in EMR. They had started prior to 2007 doing their stuff electronically. read "We thought if DMC has already done the legwork and the physicians were used to their system, then it wouldn't be such a learning curve."

HOW WAS THE IMPLEMENTATION OF YOUR SYSTEM?

We put in a specialty management system one week and the next week we put in the EMR. We thought about decreasing our patient load until we got used to it but we decided we're just going to go for it and that's what we did. A lot of solo practitioners are worried about hardware expense, how this will affect the practice, will it slow things down, will they have cash flow problems? We didn't purchase any additional hardware because everything with our EMR is web-based so all we needed was our desktop. You can use it with a tablet or laptop if you choose but it's what you feel comfortable with.

HOW DID YOU START THE PROCESS OF "MEANINGFUL USE"?

When we implemented our EMR system in March 2008 we didn't know about "meaningful use". The final guidelines for it didn't hit until December 2009 and then when they finally got the measures down we said okay where are we now for qualifying. CMS has this tool on their website where you can audit your EMR and see if you're meeting the objectives they sent out for the incentives. So we did the audit and we saw what we were missing and went back to the drawing board.

Also, you need to make sure you are credentialed with PECOs (Provider Enrollment, Chain and Ownership System) because you can't attest if you aren't credentialed. That's where you need to start first. Lastly, you need to make sure your EMR is CCHIT (Certification Commission for Health Information Technology) certified by CMS.

WHAT TIME PERIOD DID YOU USE TO ATTEST YOUR "MEANINGFUL USE"?

We made our reporting period from September 1st – December 1st of 2011. Before we started our attest period we needed to fix some things in our system that included adding certain demographic information on our patients like ethnicity or language. So we start a few months before September 1st and we would do a monthly audit, then a weekly audit and then the closer we got to starting our attest we did a daily audit. Then on December 1st we turned in our information and found out we had successfully attested for meaningful use and received the full CMS payment incentive.

WHAT UNFORESEEN REWARDS DID YOU FIND ACHIEVING "MEANINGFUL USE"?

When you meet the guidelines for meaningful use you are also making your practice audit complaint which means if you need to be audited the information is right in your EMR. Someone doesn't need to come into your office and physically go through all your charts.

WHAT WOULD YOU SAY TO OUR MEMBERS ABOUT ACHIEVING "MEANINGFUL USE"?

You can do it with your normal staff; if they can get on Facebook they can use the EMR system. Your staff doesn't need to have a background in IT, there will some training involved but you just need to set goals on what you want out of your system. Now CMS has made that easier because you want to be a meaningful user, meet and achieve their criteria to get the incentive. It's just a new way of entering and storing your practice information.

If I were a practice right now I would set my attest period for September 1st – December 1st, I would start looking for my EMR, get it in your office, prepare your office staff, get the training in and then spend the rest of the time making sure all your information is in your EMR correctly.

WHAT BENEFITS DID YOU ACHIEVE FROM YOUR EMR THAT WOULD BE BENEFICIAL FOR OUR MEMBERS TO KNOW?

In addition to the well-recognized benefit in medical information sharing and storage, it can also be a revenue generator. The addition of a practice management component that allows in-house billing, will save most physicians tens of thousands of dollars a year. The ability to do away with transcription services will save thousands of dollars a year. The in-depth documentation built into most good systems will allow the physician to code at higher levels of reimbursement and with the coming of pay-for-performance, based on the physician's actual outcomes, the ease of access to the information that will be required, also has obvious value that will reflect on the bottom line. Throw in the bonuses for e-prescribing and the CMS incentive payments and it is clear that although the initial cost of a good EMR system is substantial, once it is in "meaningful use," it will pay for itself and generate income for users. Ultimately, the better quality patient care, patient safety, and cost savings that will result from EMR's widespread implementation and use will help reach the goal of affordable health care for all Americans.

Sharon Geimer, MD

SHARON GEIMER, MD

Doctor Geimer is an internal medicine/pediatrician at Riverbend Health Care in Sterling Heights.

HOW DID YOU PICK YOUR EMR SYSTEM?

We went with the "A4" health system after previewing several systems, asking around and an evaluation of requested "demos" in my office. This system was the most intuitive and comfortable to me and was being successfully used by a few of my colleagues. I am very happy with the decision for although there is always room for improvements in resource and support, this set of applications has served us well. Now Allscripts, who owns A4, they have had a lot of growing pains. However, they have been CCHIT certified since I first learned what that meant, forward thinking and adapting in interesting ways that have improved as they grew and absorbed MISYS and other companies. Their goal-directed activities and participation

Meaningful Use Success Stories

Q&A

in support and resource of our day-to-day functions have resulted in a more successful me and a successful Riverbend team.

WHY DID YOU IMPLEMENT YOUR EMR SYSTEM?

To make care more effective and efficient; I was tired of dragging charts home at the end of the day and falling asleep over them. We wanted a better way to manage my patients and their information.

HOW DID YOU FIND THE TASK OF IMPLEMENTING AN EMR INTO YOUR PRACTICE?

CHALLENGING; well, okay challenging, that is. We did this in 2003 and have been upgrading, adapting and changing ever since. Most days I am really happy we did this, but it requires commitment and frequent innovation and renovation to maintain and continue to progress.

WHAT LEAD TO YOUR DECISION TO ACHIEVE "MEANINGFUL USE"?

As a practice we try to engage in and implement quality improvement on a regular basis. Interactive capability with other entities such as the immunization registry, hospital and physicians has always been my goal. Along with patient satisfaction, optimal management of their problems/conditions and prevention needs to achieve our mutual goals. My latest motto is Efficiency, Effectiveness and Excellence with Ease. So the fact that we had an EMR for a long time and that rewards were available for demonstrating usefulness seemed like a good fit.

WHAT TIME PERIOD DID YOU TAKE TO ACHIEVE "MEANINGFUL USE"?

Our attestation was a 90-day time period from July 1st to October 1st of 2011. We spent about 18-24 months before that preparing and learning about details of meaningful use--attending seminars, conferences and work groups. This included work with our software vendor but a lot more work with quality improvement projects and staff meetings. We learned we were successful for Phase One in December 2011 when we received our financial reward. We are continuing to implement changes and attempting to be successful in the next phase which is a full year; from January through December 2012 – I'll keep you posted.

WHAT UNFORESEEN REWARDS DID YOU FIND ACHIEVING "MEANINGFUL USE"?

Utilizing multiple resources and engaging our staff to be a team and to problem solve through the many challenges meaningful use has presented. I have seen my staff grow and function better as a team. With this and other quality improvement projects we participate in, our patients have benefited. It's a lot more work right now, but the implementation and integration that are continuing have the potential to make it easier to care for patients. It's already better in terms of communication.

WHAT ADVICE WOULD YOU GIVE OTHER COLLEAGUES WHO ARE IN THE PROCESS OF ACHIEVING "MEANINGFUL USE"?

Keep trying and looking for multiple resources if you need them as sometimes "it takes a village." Of course, in this case not to raise a child so much, as to implement technological solutions to problems that seem they should be easier to solve.

DO YOU THINK IT WAS HARDER OR EASIER AS A SMALL PRACTICE TO IMPLEMENT AN EMR AND ACHIEVE "MEANINGFUL USE"?

Both harder because of limited resources (people and dollars) and easier because as a solo practitioner I make the decisions and implement changes so it is easy to measure who and what is changing--and make sure those changes are happening and effective.

DO YOU HAVE ANY FURTHER COMMENTS THAT YOU THINK OUR PHYSICIAN MEMBERS MIGHT FIND BENEFICIAL?

I would recommend going after meaningful use as a way to integrate and implement EMR use for your practice/patients. The monetary reward is nice, but the incredible work and monetary investment involved to achieve that had to have far more reaching positive effects and benefits for me to feel that all this effort is worthwhile. I am convinced that it has been a winning situation for me, for our patients and for my staff.

Upcoming CME Opportunities

For more information on the CME programs listed below visit www.msms.org/eo, or call (517) 336-7581 (unless otherwise stated). Additional CME programs can be found online under the CME section of the OCMS website at www.ocms-mi.org.

April 12, 2012
The Winding Road of Primary Care
Registration: 7:30 a.m.; Program: 8:00 – 11:00 a.m.
Somerset Inn, Troy

April 12, 2012
Health Insurance 101
Registration: 12:30 p.m.; Program: 1:00-4:00 p.m.
Somerset Inn, Troy

April 12, 2012
Nuts and Bolts of Non-Physician Practitioners
Registration: 11:30 a.m.; Program: 12:00 – 3:00 p.m.
Somerset Inn, Troy

April 12, 2012
Pain Management Billing
Registration: 4:30 p.m.; Program: 5:00 – 8:00 p.m.
Somerset Inn, Troy

April 24, 2012
Office Manager 101
Registration: 12:30 p.m.; Program: 1:00-4:00 p.m.
Hilton Garden Inn, Novi

April 24, 2012
Physician Quality Reporting Initiative
Registration: 12:30 p.m.; Program: 1:00-4:00 p.m.
Hilton Garden Inn, Novi

April 24, 2012
Countdown to ICD-10
Registration: 4:30 p.m.; Program: 5:00 – 7:00 p.m.
Hilton Garden Inn, Novi

April 24, 2012
Successful Strategies for Patient Satisfaction
Registration: 4:30 p.m.; Program: 5:00 – 8:00 p.m.
Hilton Garden Inn, Novi

May 3, 2012
Orthopedic Coding and Billing
Registration: 12:30 p.m.; Program: 1:00-4:00 p.m.
Hilton Garden Inn, Novi

May 3, 2012
Michigan Work Comp Rules
Registration: 4:30 p.m.; Program: 5:00 – 8:00 p.m.
Hilton Garden Inn, Novi

May 8, 2012
Basic Fundamentals of ICD-9 Coding
Registration: 12:30 p.m.; Program: 1:00-4:00 p.m.
Somerset Inn, Troy

May 8, 2012
Advanced ICD-9 Coding
Registration: 12:30 p.m.; Program: 1:00-4:00 p.m.
Somerset Inn, Troy

May 8, 2012
Basic Fundamentals of CPT Coding
Registration: 4:30 p.m.; Program: 5:00 – 8:00 p.m.
Somerset Inn, Troy

May 8, 2012
Advanced CPT Coding
Registration: 4:30 p.m.; Program: 5:00 – 8:00 p.m.
Somerset Inn, Troy

May 16, 2012
Patient Centered Medical Home
Registration: 12:00 p.m.; Program: 12:30 – 8:00 p.m.
Somerset Inn, Troy

May 22, 2012
Documentation of E&M Services
Registration: 12:30 p.m.; Program: 1:00 – 8:00 p.m.
Hilton Garden Inn, Novi

May 22, 2012
Medical Records and the Law
Registration: 12:30 p.m.; Program: 1:00 – 4:00 p.m.
Hilton Garden Inn, Novi

May 22, 2012
Preparing for the OIG: Are You Complaint?
Registration: 12:30 p.m.; Program: 1:00 – 3:00 p.m.
Hilton Garden Inn, Novi

May 23, 2012
Leadership Summit
Registration: 8:30 a.m.; Program: 9:00 a.m.-3:00 p.m.
Cooley Temple Conference Center, Lansing

June 7, 2012
Advanced Coding for the Advanced Coder
Registration: 7:30 a.m.; Program: 8:00 -11:00 a.m.
Hilton Garden Inn, Novi

June 7, 2012
Countdown to ICD-10
Registration: 4:30 p.m.; Program: 5:00 – 7:00 p.m.
Hilton Garden Inn, Novi

June 13, 2012
Health Information Technology (HIT) Symposium
Registration: 12:30 p.m., Program: 1:00 – 8:00 p.m.
Birmingham Conference Center, Beverly Hills

Practice Management

Tips For Creating A Patient Satisfaction Survey

By Madeline Hyden, MGMA Web Content Writer/Editor

Satisfied patients can improve your bottom line by staying loyal to your practice and referring new patients. But with the increased number of clinics cropping up in grocery stores, pharmacies and other retail centers, patients have other options for care if they're unhappy with the service at your practice. According to data from the Deloitte Center for Health Solutions, the number of retail clinics grew by 40 percent from 2008 to 2009. These walk-in clinics offer treatment for minor illnesses such as colds or ear infections, as well as maintenance care, such as sports physicals.

Patient satisfaction surveys are an easy way to gauge the needs of your patients and whether you're meeting them. Responses from patient satisfaction surveys, especially if patients describe a specific visit, can offer a snapshot of a larger issue in your practice. Use these tips for your patient satisfaction survey:

- Determine your timeline for distributing the survey. Do you want to collect satisfaction data once a year or on an ongoing basis? Do you want an overall rating or a rating for an individual appointment?
- Include questions about patient flow, parking, wait times, appointment availability and physician communication style. Retail clinics are appealing to patients who need a short-notice appointment or have a problem outside of normal practice hours. Is it possible for your practice to offer those services?
- Ask patients to give details on their perception of their care. Are their questions answered during each visit? If they have a chronic condition, do the physician and staff give them adequate education and resources? This can provide insight into improving patient compliance and quality measures.
- Consider using an online platform for your patient satisfaction surveys. Sites such as SurveyMonkey and Zoomerang offer basic services for free, and you can view your results online. Send your patients a link to take the survey via e-mail or post a link on your practice website, if you have one.
- Ask questions about improvements to patient communication, such as, "Would you be interested in an online patient portal to view your lab results and schedule appointments?"
- Give patients the option of submitting their surveys anonymously.
- Ask who each patient's favorite staff member is and why. Share that information with that person to boost morale.
- Encourage clinic and front-office staff to ask patients to participate in the survey.
- Use the survey feedback to help make decisions in your practice workflow and hiring. Patient feedback can serve as a job assessment tool.
- Ask patients if they have ever referred someone to your practice; if not, would they consider doing so.
- Use MGMA's Performance and Practices of Successful Medical Groups – 2010 Report Based on 2009 Data to see what top-performing practices include in their patient satisfaction surveys.

Direct link to article on MGMA website - http://www.mgma.com/blog/Tips-for-creating-a-patient-satisfaction-survey/
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Medical Group Management Association
MGMA
Michigan
A State Affiliate

SAVE THE DATE!

MMGMA Fall 2012 Conference

September 20th – 21st

Grand Traverse Resort & Spa, Acme, MI

For more information please contact Sherry Barnhart, Executive Secretary
Tel. (517) 336-5786, E-mail: sbarnhart@michmgma.org

MARK YOUR CALENDAR FOR OUR NEXT OCMS PRACTICE MANAGERS' MEETING

Tuesday, May 1st

8:30 a.m., light breakfast, 9:00 - 10:00 a.m. meeting
The Community House, Birmingham

All OCMS Practice Managers' are welcome to attend. Please RSVP to Donna LaGosh at dlagosh@msms.org or 248-773-4000.

PRACTICE MANAGERS HAVE ACCESS TO TOOLS AND RESOURCES VIA PHYSICIAN MEMBERSHIP

As physician members, you should already be taking advantage of the services and benefits offered through your membership in the Oakland County Medical Society and the Michigan State Medical Society. But you can also take advantage of additional services that benefit your practice manager as well.

OCMS and MSMS provide a number of services such as a payer solutions network, health plan contracting toolkit, coding assistance, practice manager meetings (see above), articles related to practice management issues and much more. If you have any questions on these services or how to access them please contact Donna LaGosh at dlagosh@msms.org or 248-773-4000.

PHYSICIAN SPOTLIGHT

Stanley Dorfman, MD & Robert Robins, MD

In this physician spotlight OCMS would like to honor the mission work of two of our members, Stanley Dorfman, MD and Robert Robins, MD.

Doctor Stanley Dorfman, an obstetrician and gynecologist, made a mission trip in January of this year to Santiago City in the province of Isabela, Philippines. This was Dorfman's second mission trip; his first one was to India a few years ago.

He heard about the mission trip through his former partner, Doctor Robert Robins. Doctor Dorfman and Doctor Robins had practiced together from 1984 until Doctor Dorfman's retirement in 2009. Three years ago Doctor Robins had gone to the Philippines with an organization called the Philippine Medical Association of Michigan. He brought back pictures from the trip to show Doctor Dorfman who decided that once he retired they would both go together (since both couldn't be out of the practice at the same time).

The Philippine Medical Association of Michigan schedules trips to the Philippines every two years. This is because it takes two years to get it planned and find a sponsor for the trip. On this particular trip they were able to have the mayor of the town sponsor them. "There is a lot of work involved because we need a sponsor, we have to get our medical licenses approved and they close down their operating rooms for us while we are there," said Doctor Robins. "They also have to inform the physicians so that they can find the patients who needs surgeries but can't afford them."

Doctor Dorfman said more than 80 medical people went on the trip. "Doctor Robins and myself did a total of 19 surgeries in four days, but between all of the physicians who went on the trip we saw more than 1,500 Pediatric and Internal Medicine patients and did close to 100 surgeries," said Doctor Dorfman.

There is also no health insurance in the Philippines. "There's no middle class in the Philippines; there's wealthy or poor, so unless you can afford to pay for surgery, you can't get surgery," added Doctor Dorfman.

Doctor Robins said the conditions they worked in are quite different than what we have in the United States. "On my first trip to the Philippines I was in a town called Pampanga. The room I scrubbed in was no bigger than 4'x10', I had a gooseneck lamp to scrub by, no suction or cautery and we used our own equipment we had brought. Luckily, the cases weren't as difficult as the surgeries we did this year in Santiago. We had a more modern hospital, the suction worked, we had overhead operating lights and a cautery machine."

The surgeries they performed in Santiago were mainly on women in their 30s and 40s. Most of them were for endometriosis, fibroids, or ovarian cysts. "Most of the women with fibroids had a uterus that was the size of a four-and-a-half month pregnancy. I was shocked that every other patient I operated on had endometriosis or fibroids. They just lived with the pain." said Doctor Robins.

Doctor Dorfman added that while these were major surgeries, all they had to give the patients for pain were Motrin 600mg for three-four days. "Most went home the following day or the second day. They had to lie on little mattresses like you use for camping," said Doctor Dorfman. "Their families would come and help them. They were all so appreciative. We never heard them complain."

"I was shocked that every other patient I operated on had endometriosis or fibroids. They just lived with the pain."

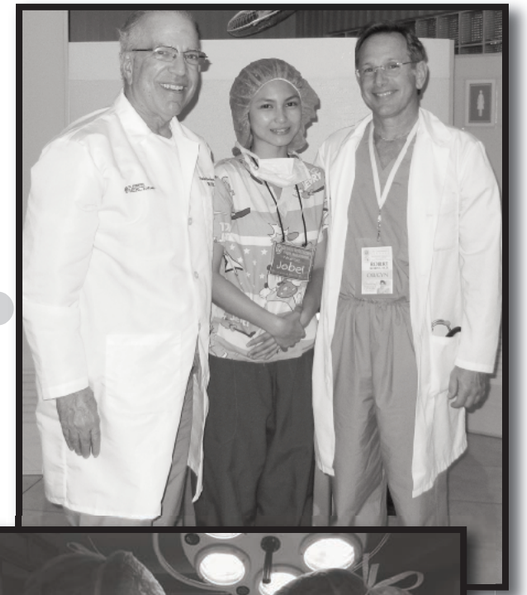
Dorfman and Robins both recalled a patient that had been living with her condition since the last mission trip came through four years ago.

"There was a lady who was 38 years old, four years ago she had a breast biopsy that was cancerous but she had to wait for the next mission to come in to get the surgery. By the time we saw her, the breast was full of tumors," said Docotr Dorfman, "Unfortunately, this was probably preventable four years ago. She's going to try to get chemotherapy, but if she doesn't have the money she won't get it."

Both physicians also agreed that the trip was not only challenging but also very rewarding.

"I remember coming back from my first mission and people would say what was so great, you've been helping patients your whole career," commented Doctor Dorfman, "But if I wasn't here the patients would find another physician, but there the people just wouldn't get the care. So it was so gratifying what we could do for them, a really remarkable experience. I would encourage any physician who has the opportunity to do so."

Doctor Robins added, "In the Philippines, we were able to perform difficult surgeries under less than ideal conditions. It is very invigorating to have to improvise and use all of your skills in order to reach your desired outcome. It is so exhilarating to see your patient the next day doing so well and being so appreciative. It was also very refreshing to simply practice the skills of our profession without the burdens of EMR, computers, billing and the like.



DOCTOR DORFMAN retired from his OB/GYN practice after 36 years in 2009 and is now the Director of Medical Education for St. Joseph Mercy Oakland. He oversees all the education programs and residencies. He was also former Chief of Staff at St. Joe's and Chair of the Physician's Operation Strategic Team. At OCMS he was President of the Board of Directors in 1995 and helped to start our involvement in the Gift of Life Michigan which he is still involved in today.

DOCTOR ROBINS is a practicing OB/GYN for Associated Obstetrics & Gynecology with offices in Bloomfield Hills and Clarkston. He is on the OB/GYN advisory board at St. Joe's and an assistant clinical professor at the Ross School of Medicine.

DONOR REGISTRY HAS RECORD YEAR

Gift of Life applauds Secretary of State Ruth Johnson and all SOS workers for their efforts in helping build the burgeoning registry last year. In April, Johnson announced a new policy to encourage workers at branch offices to ask customers if they would like to join the registry - a first in Michigan.

That policy change lead to double-digit increases in the donor registry in every month through the rest of the year.

"We can't thank Secretary Johnson enough for recognizing a small change that could potentially save lives," said Richard Pietroski, Gift of Life's CEO. "She has given new hope to thousands of critically ill patients."

The growth of the registry is critical to helping save the lives of the 3,000 people waiting today for organ transplants.

One of those waiting for a transplant is Jai'Wan Davis-Harbour, 11, of Taylor.

"My son Jai'Wan desperately needs a kidney to survive and live a normal life without dialysis. What Secretary Johnson has done gives us hope that the phone call we're waiting for will finally come," said his mom, Cherisse Davis-Harbour.

GIFT OF LIFE
MICHIGAN ORGAN & TISSUE DONATION PROGRAM
GIVE SO OTHERS CAN LIVE

~MICHIGAN DONOR DRIVE 2012~

Organ Donation Materials Order Form

Please provide the following information so we can send you support materials.

Medical Practice/Hospital Name: _____

Contact Person: _____

Shipping Address (no PO Boxes please):_____Suite: _____

City: _____ State: MI Zip: _____

Phone: (_____) _____ Email: _____

FREE SUPPORT MATERIALS

QTY	ITEM	DESCRIPTION
___	Donor Registry brochures	Answers common questions, includes postage-paid registry form
___	Pens	Gift of Life Michigan pens
___	Posters	Posters promoting organ, tissue and eye donation (styles may vary)

Fax form to (248) 773-4004 or mail to: OCMS, 41800 W. 11 Mile Road, Suite 215, Novi, MI 48375, Attn: Cindy Dady

YOUNG PHYSICIANS FAMILY BOWLING DAY

Over 60 residents, fellows, and young physicians from Oakland and Wayne County Medical Societies enjoyed an afternoon of bowling, food and fun at Bowlero Lanes in Royal Oak, Saturday, February 11th.

SAVE THE DATE!

Oakland County Medical Society & Wayne County Medical Society of SE Michigan

3rd Annual Family Fun Day at The Detroit Zoo!

Sunday, August 5th

More details coming soon!

JOIN US for the 1st Annual OCMS Family Picnic & Barbeque Saturday, June 2nd

Springdale Park, Birmingham
More details coming soon!

OCMS MEMBER REMINDERS

OCMS IS GOING DIGITAL!

Starting with the February 2013 issue, there will no longer be a print version of the OCMS Bulletin. It will only be available in our new digital flipbook format. We will also be combining our E-Bulletins with our Quarterly Bulletins so members will have access to six issues of our new digital bulletin. The new digital bulletin will be sent to our members by email and then posted on our web site. If you have any questions on this new format please call OCMS at 248-773-4000.

OCMS MEMBER DIRECTORY UPDATES

OCMS members should have received in the mail a directory update form. It is very important that we have your changes for our 2012-2013 member directory, which will be published in July, by **Tuesday, May 1st.** If you did not receive a form please call the OCMS office at 248-773-4000 or email Pat Grebeck, pgrebeck@msms.org.

Electronic Health Records: What Physicians Should Know Beyond Meaningful Use and Incentive Payments

MEDICAL/LEGAL COMMITTEE MEETINGS

All physician members are welcome to attend the Medical/Legal Committee meetings held at the Oakland County Bar Association (OCBA), the 1st Thursday of every month at 7:45 a.m. The complete calendar is available on the OCMS website under Committees. The OCBA is located at 1760 Telegraph Road, Suite 100, Bloomfield Hills, 248-334-3400.

By Robert S. Iwrey, Esq., Stephanie P. Ottenwess, Esq. and Neda Mirafzali, Esq.

The benefits to adopting a certified electronic health records ("EHR") system are numerous, including a continuous medical record, incorporating notes from all physicians and practitioners treating a patient (assuming they utilize an EHR system), and increased efficiency in documenting care, to name a few. Lately, physicians have been flooded with information from the Centers for Medicare and Medicaid Services and others regarding the opportunity to receive incentive payments for meaningfully using EHR. This financial push is working as the National Center for Health Statistics issued a Data Brief in November 2011 indicating 57% of office-based physicians used an EHR system in 2011, a 38.8% increase since 2001.

Importantly, however, many providers may know little beyond the fact that if certain requirements are met, they could earn up to $42,500 in Medicare incentive payments over six years. While this number is enticing and has been a catalyst to increased EHR adoption, prior to purchasing and implementing an EHR program, physicians must conduct their due diligence to avoid exposure to certain legal risks and liabilities uniquely associated with EHR systems.

Emergence of a New Kind of Medical Error

While the adoption of EHR is aimed at increasing timely access to complete patient information among providers and decreasing confusion and mistakes associated with the record, increased dependence on computerizing the process gives rise to a new set of errors that would likely not appear in the hand-written, paper records. These new types of errors may lead to greater exposure for providers in the face of increased scrutiny in the submission of claims and with respect to professional malpractice actions.

For example, many EHRs have built in "time savers," such as self-populating fields that insert a patient's medical or procedural history into each record. These time-saving devices ultimately may hurt a provider if not used correctly. Auditors and claim reviewers may deny claims for medical necessity if it appears that the documentation is not tailored to the service performed, but is merely a template. Additionally, claims may be denied if it is determined that the medical records associated with the service or procedure are internally inconsistent. For example, claims have been denied because the medical record states in one area: "patient has no complaints of pain," but in another area states: "patient presents with severe pain."

In some cases, EHR systems may automatically generate a prescription, including strength and form, based on the notes in the record. In such instances, the provider must take care on two levels. Firstly, the provider must ensure that the prescription generated by the EHR system is appropriate for the patient. Though the system is convenient in generating the prescription, nothing can substitute for the professional judgment of the provider. Secondly, if the provider does, in fact, change the EHR-system-generated-prescription, the provider must ensure that such alterations are also reflected in the exam note itself. Other providers will rely on that exam note to make future decisions on refilling the prescription or prescribing another medication.

Liability can also arise by missing simple spelling errors, despite spell check (e.g., writing care instead of case). The ease with which certain tasks can be completed has resulted in increased carelessness on all of our parts. In the EHR world, however, those careless mistakes could have much greater implications, including risks of patient safety, medical malpractice claims or audit activity.

Above All: Know Your EHR System

In order to decrease potential liability, providers using EHR must ensure that they understand the capabilities of the software, have knowledge regarding which fields self-populate, and tailor each record to the patient's condition at the time of assessment. In order to accomplish these goals, providers must perform significant due diligence during the search for, and after implementation of, an EHR system.

First, the provider must make certain that he/she has found the right system, tailored to his/her particular practice. Next, knowing the system and how to use the system correctly is essential. Providers and their staffs must take the time to learn the system and be properly and thoroughly trained and re-trained when program updates occur. Providers and their staff should know, for instance, whether their EHR system has an auto-populating function and whether it can be disabled, whether the prescription-generating function can be customized and whether the entire EHR system can be custom-made to fit within the provider's current practice.

Negotiate with the EHR System Provider

Before EHR adoption, when contracting with an EHR system provider, the key to remember is: negotiate, negotiate, negotiate. In addition to negotiating the obvious provisions regarding price and warranties, one of the most important points of negotiation will be liability. Specifically, the EHR system provider may include in the agreement that it will be absolved from all liability for issues arising from its EHR system. In other words, according to the contract, the provider will be liable for all errors that occur from using the EHR system, even if the provider was properly utilizing the EHR system.

Merely accepting the status quo and limited liability of the EHR system provider could be problematic for the healthcare provider should issues arise from a faulty EHR system. While true that EHR failure can be the result of human vs. computer or software-related error, what is certain is that electronic documentation can enhance the evidence available to assess claims and the resulting liability by a Court or other trier of fact. A provider with a faulty EHR system can thus be placed at greater risk.

At this early stage of EHR use and implementation, it is not clear how the law will evolve to allocate liability among providers and EHR developers. As such, healthcare providers should try to insulate themselves, as best as possible, from liability resulting from faulty EHR systems in areas including breach of confidentiality and privacy; medical malpractice and compliance issues.

Conclusion

The benefits associated with adopting an EHR system can be great both clinically and financially. However, a provider's failure to properly understand the EHR system and his/her liabilities under the agreement could result in a greater headache than anticipated. Proper education on the EHR system and engaging well-qualified legal counsel is crucial in realizing the maximum benefit of EHRs.

For more information on the authors of this article please go to Page 27.

MEMBERSHIP REPORT

The following physicians have recently been elected into membership in OCMS

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Internship: Medical City Hospital, Baghdad, Iraq - 1974-1975; Oakwood Hospital, Dearborn, MI - 1980-1981
Residency: Providence Hospital-Southfield (Diagnostic Radiology) - 1981-1984
Primary Specialty: Diagnostic Radiology
Board Certifications: American Board of Radiology – 1985
Hospital Affiliations: Garden City Hospital, Providence Hospital-Southfield, Providence Park Hospital-Novi

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NW Internal Medicine-Millennium Medical Group
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Residency: Sinai-Grace Hospital
Primary Specialty: Internal Medicine
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Medical School: Wayne State University School of Medicine, Detroit, MI, 1985
Residency: Henry Ford Hospital, Internal Medicine, Chief Resident - 7/88 - 6/89 (1988)
Fellowship: Henry Ford Hospital, Gastroenterology - 1992
Primary Specialty: Gastroenterology Secondary Specialty: Internal Medicine
Board Certifications: American Board of Internal Medicine, American Board of Internal Medicine-Gastroenterology
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St. John Macomb-Oakland Hospital
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Medical School: Indiana University School of Medicine, Indianapolis, Indiana, 1993
Internship: William Beaumont Hospital - Royal Oak
Residency: William Beaumont Hospital - Royal Oak (Emergency Medicine) - 1993-1996
Primary Specialty: Emergency Medicine
Board Certifications: American Board of Emergency Medicine
Hospital Affiliations: St. John Macomb-Oakland Hospital

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Internship: Combined with residency at William Beaumont
Residency: William Beaumont, Troy, MI (Family Practice) - 1996-1999
Primary Specialty: Family Medicine
Board Certifications: American Board of Family Practice - 1999
Hospital Affiliations: William Beaumont Hospital-Troy

Nancy Couch, MD
Medical School: Wayne State University, Detroit, MI, 1982
Residency: 2 yrs. at WSU Affiliate Hospitals (Internal Medicine) and 1 yr. at Henry Ford - Internal Medicine – 1985; University of Michigan Affiliate Hospitals (Geriatrics) - 1987
Primary Specialty: Internal Medicine Secondary Specialty: Geriatric Medicine-Internal Medicine
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Hospital Affiliations: None

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Residency: St. John Hospital, Detroit, MI - Combined Residency & Internship (General Pediatrics) – 1984-1987
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Board Certifications: American Board of Pediatrics – 1989
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Internship: Providence Hospital, Southfield, MI (General Surgery) - 6/1997-6/1998
Residency: Providence Hospital, Southfield, MI (General Surgery) - 6/1998-6/2002
Fellowship: Mayo Clinic (Div. of Colon & Rectal Surgery) - 7/2003-6/2004
Primary Specialty: Colon & Rectal Surgery Secondary Specialty: General Surgery
Board Certifications: ABMS Board of Surgery, ABMS Board of Colon & Rectal Surgery
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Board Certifications: American Board of Internal Medicine - 1995
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Primary Specialty: Internal Medicine
Board Certifications: American Board of Internal Medicine
Hospital Affiliations: Providence Hospital-Southfield, Providence Park Hospital-Novi

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Residency: Methodist Hospital of Indiana, Indianapolis, IN (Pediatrics) - 1980-1983
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Board Certifications: American Board of Pediatrics - 1989
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Internship: William Beaumont-Royal Oak, Cardiology - 7/03-6/04
Residency: William Beaumont-Royal Oak, Cardiology - 7/04-6/06
Fellowship: William Beaumont-Royal Oak, Cardiac Electrophysiology - 2009-2010 & Clinical Cardiovascular Medicine - 2006-2009
Primary Specialty: Cardiovascular Diseases
Board Certifications: American Board of Internal Medicine-2006, American Board of Internal Medicine-Cardiovascular Disease
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Primary Specialty: Ophthalmology
Board Certifications: American Board of Ophthalmology
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Primary Specialty: Family Medicine
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Internship: Overlook Hospital, Summit, NJ - Transition - 7/88-6/89
Residency: Overlook Hospital, Summit, NJ - Diagnostic Radiology - 7/89-6/93
Fellowship: Thomas Jefferson University Hospital, Philadelphia, PA - Cross Sectional Imaging - 7/93-6/94
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Primary Specialty: Internal Medicine
Board Certifications: American Board of Internal Medicine - 2008
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Primary Specialty: Neurology
Board Certifications: American Board of Neurology - 2006, American Board of Vascular Neurology - 2008
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Residency: Providence Hospital-Southfield - 7/97-6/01
Fellowship: University of Michigan, Ann Arbor, MI - Body Imaging - 7/01-7/02
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IPC- The Hospitalist Company
4967 Crooks Rd., Ste. 130, Troy, MI 48098
Phone: 248/952-1601 Fax: 248/952-1614
Medical School: University of Ibadan, Oyo State, Nigeria - 1988
Internship: Sinai Hospital of Detroit – 1994-1995
Residency: Henry Ford Hospital, Detroit, MI – 1995-1997
Primary Specialty: Internal Medicine
Board Certifications: American Board of Internal Medicine - 1997
Hospital Affiliations: Henry Ford Macomb Hospital

Liberata J. Pantig, MD
Huron Medical Center Clinic
1117 S. Van Dyke, Ste. 400, Bad Axe, MI 48413
Phone: 989/269-6048 Fax: 989/269-6174
Medical School: University of Santo Tomas, Manila, Philippines - 1965
Residency: Highland Park General Hospital, Highland Park, MI (Internal Medicine) - 1970
Fellowship: Henry Ford Hospital, Detroit, MI (Hematology) - 1972
Primary Specialty: Internal Medicine
Hospital Affiliations: Huron Medical Center Clinic

Shalini Singh, MD
Deighton Family Medicine
22250 Providence Dr., Ste. 500, Southfield, MI 48075
Phone: 248/849-3441 Fax: 248/849-5389
Medical School: Wayne State University School of Medicine, Detroit, MI, 1999
Residency: Providence Hospital & Medical Centers, Southfield, MI (Family Practice) - 1999-2002
Primary Specialty: Family Medicine
Board Certifications: American Board of Family Medicine – 2001
Hospital Affiliations: Providence Hospital-Southfield, Providence Park Hospital-Novi

Michael E. Stachecki, MD
5730 Bella Rosa Blvd., Ste. 200, Clarkston, MI 48348
Phone: 248/620-1720 Fax: 248/620-1740
Medical School: Wayne State University Medical Center, Detroit, MI - 1991
Residency: St. Joseph Mercy Oakland Hospital (IM & PD) - 1995
Primary Specialty: Internal Medicine Secondary Specialty: Pediatrics
Board Certifications: American Board of Internal Medicine, American Board of Pediatrics
Hospital Affiliations: Crittenton Hospital, St. Joseph Mercy Oakland

MEMBERSHIP REPORT

Ivana M. Vettraino, MD
Oakland-Macomb OB/GYN, PC
1701 South Blvd. E., Ste. 200, Rochester Hills, MI 48307
Phone: 248/997-5805 Fax: 248/997-5811
Medical School: University of Michigan Medical School, Ann Arbor, MI - 1988
Internship: Barns Hospital, Washington University, St. Louis, MO - 1988-1989
Residency: Washington University in St. Louis School of Medicine, Obstetrics & Gynecology - 1989-1992
Fellowship: Washington University in St. Louis School of Medicine, Maternal-Fetal Medicine - 1992-1994
Primary Specialty: Obstetrics & Gynecology
Board Certifications: American Board of Obstetrics & Gynecology-Maternal & Fetal Medicine - 1981
Hospital Affiliations: William Beaumont Hospital-Royal Oak, William Beaumont Hospital-Troy

Chung Y. Wang, MD
Rochester Anesthesiologist, PC
441 S. Livernois, Ste. 190, Rochester, MI 48307-2591
Phone: 248/656-9696 Fax: 248/656-5731
Medical School: National Taiwan University - 1967
Internship: Evanston Hospital, Illinois (Transitional) - 1969
Residency: Evanston Hospital, IL (Pathology) 1970; Mercy Hospital & Medical Center (General Surgery) - 1971; Wayne State University, Detroit (General Surgery) - 1972; Henry Ford Hospital, Detroit (Anesthesiology) - 1974
Primary Specialty: Anesthesiology
Board Certifications: American Board of Anesthesiology
Hospital Affiliations: Crittenton Hospital

LoriAnn Washe, MD
Premier Private Physicians
6483 Citation Dr., #B, Clarkston, MI 48346
Phone: 248/922-3074 Fax: 248/922-3081
Medical School: Chicago Medical School Rosalind Franklin University of Medicine and Science, IL, 1996
Residency: William Beaumont Hospitals, Troy, MI - 1996-1997
Primary Specialty: Family Medicine
Board Certifications: American Board of Family Medicine
Hospital Affiliations: William Beaumont Hospital-Royal Oak, William Beaumont Hospital-Troy

Beata Kostrzewa Weiermiller, MD
Somerset Gynecology & Obstetrics
3290 W. Big Beaver Road, Ste. 444, Troy, MI 48084
Phone: 248/816-9200 Fax: 248/816-1017
Medical School: Michigan State University College of Human Medicine, E. Lansing, MI, 1994
Residency: Indiana University Medical Center, Indianapolis, IN - 1994-1998
Primary Specialty: Obstetrics & Gynecology
Board Certifications: American Board of Obstetrics and Gynecology
Hospital Affiliations: William Beaumont Hospital-Royal Oak

Jeremy D. Wolfe, MD, MS
Associated Retinal Consultants, P.C.
39650 Orchard Hill Place, Ste. 200, Novi, MI 48375
Phone: 248/319-0161 Fax: 248/319-0170
Medical School: University of Toledo College of Medicine, Toledo, Ohio, 2004
Internship: Emory University, Dept. of Ophthalmology, Atlanta, GA (Dept. of Transitional Medicine) - 2004-2005
Residency: Emory University, Dept. of Ophthalmology, Atlanta, GA - 2005-2008
Fellowship: Wills Eye Institute, Vitreo Retinal Surgery, Philadelphia, PA - 2008-2010
Primary Specialty: Ophthalmology
Board Certifications: American Board of Ophthalmology - 2009
Hospital Affiliations: William Beaumont Hospital-Royal Oak

Jennifer L. Wulff, MD
Healthy Urgent Care
7125 Orchard Lake Rd., Ste., 100, West Bloomfield, MI 48322
Phone: 248-865-7444
Medical School: American Univ. of the Caribbean, School of Medicine, St. Maarten, Netherlands Antilles,
Residency: Providence Hospital Family Medicine, Southfield, MI - 7/1/08-9/1/11
Primary Specialty: Family Medicine
Board Certifications: American Board of Family Medicine - 2011
Hospital Affiliations: Providence Hospital-Southfield, Providence Park Hospital-Novi

Erik D. Zuckerberg, MD
Orion Family Physicians
1455 S. Lapeer Rd., Ste. 100, Lake Orion, MI 48360
Phone: 248/693-3551 Fax: 248/693-4643
Medical School: Wayne State University School of Medicine, Detroit, MI, 1994
Residency: William Beaumont Hospital–Troy – 1997 completed
Primary Specialty: Family Medicine
Board Certifications: American Board of Family Medicine – 1997
Hospital Affiliations: William Beaumont Hospital-Troy

NEW MEMBERSHIP CORRECTION – The following new members' information was listed incorrectly or absent from our December/January issue. We apologize for the inconvenience.

Kertia Libretto Black, MD
WSU UPG
261 Mack Blvd., Detroit, MI 48201
Phone: 313-745-1218 Fax: 313-745-1165
Medical School: Hahnemann University School of Medicine, Philadelphia, 1989
Residency: University of Pennsylvania, Philadelphia - 1993
Primary Specialty: PM
Hospital Affiliations: Detroit Medical Center; Rehabilitation Institute of Michigan
Board Certifications: American Academy of Physical Medicine and Rehabilitation

David A. Brill, MD
Cardiology Consultants of East Michigan
1031 Suncrest, Lapeer, MI 48446
Phone: 810-664-4870 Fax: 810-664-0921
Medical School: Columbia University College of Physicians & Surgeons, New York, NY, 1983
Internship: Yale New Haven Hospital, New Haven, CT - 6/1983 to June/1984
Residency: Yale New Haven Hospital, New Haven, CT - June/1983 to June/1986 - Internal Medicine
Fellowship: Johns Hopkins Hospital, Baltimore, MD - January 1987 - July 1989
Primary Specialty: CD
Board Certifications: American Board of Cardiology, American Board of Internal Medicine
Hospital Affiliations: Genesys Regional Medical Center, Hurley Medical Center, Lapeer Regional Medical Center, McLaren Regional Medical Center, William Beaumont Hospital-Troy

Deirdre L. Claiborue, MD
Center for Senior Independence
7800 W. Outer Dr., Ste. 240, Detroit, MI 48235
Phone: 313-543-6200
Medical School: Wayne State University, Detroit, MI, 1995
Residency: Wayne State University, Detroit, MI (Family Medicine)
Primary Specialty: FM
Board Certifications: American Board of Family Medicine
Hospital Affiliations: Henry Ford Hospital

Stephen Roberts Cluff, DO
Henry Ford West Bloomfield
6777 W. Maple Road, West Bloomfield, MI 48322
Phone: 1-800-436-7936
Medical School: Arizona College of Osteopathic Medicine, Midwestern University Glendale Campus, 2006
Residency: Henry Ford Macomb Hospital - Emergency Medicine - 6/06 – Present
Primary Specialty: EM
Hospital Affiliations: Henry Ford Hospital, Henry Ford Macomb Hospital, Henry Ford West Bloomfield

Colleen Conway Grace, MD
Henry Ford OptimEyes Super Vision Center
35184 Central City Parkway, Westland, MI 48185
Phone: 1-800-436-7936
Medical School: University of Michigan, Ann Arbor, MI 2003
Internship: St. Joseph Mercy Hospital, Ann Arbor, MI
Residency: University of Maryland Medical Center, Baltimore, MD – Ophthalmology
Fellowship: University of Wisconsin, Madison, WI- Cornea/External Disease Clinical Uveitis
Primary Specialty: OPH
Board Certifications: American Board of Ophthalmology
Hospital Affiliations: Henry Ford Hospital

Electronic Health Records:

Continued from Page 21.

Robert S. Iwrey *is a founding partner of The Health Law Partners, P.C., where he focuses his practice on licensure, staff privileges, litigation, dispute resolution, contracts, Medicare, Medicaid and Blue Cross/Blue Shield audits and appeals, defense of health care fraud matters, compliance, employment matters and other healthcare related issues. He may be contacted at (248) 996-8510 or riwrey@thehlp.com.*

Stephanie P. Ottenwess *is a partner with The Health Law Partners, P.C., where she practices healthcare law representing providers and suppliers in healthcare litigation, providing counsel regarding fraud and abuse, compliance and reimbursement matters; and is consulted by both healthcare facilities and practice groups for her critical evaluation of any issue affecting risk management, including EHR adoption. Contact her at (248) 996-8510 or sottenwess@thehlp.com.*

Neda Mirafzali *is an associate with The Health Law Partners, P.C. and practices in all areas of healthcare law, assisting clients with transactional and corporate matters; representing providers and suppliers in healthcare litigation matters; providing counsel regarding compliance and reimbursement matters; and representing providers and suppliers in third party payor audit appeals. She can be reached at (248) 996-8510 or at nmirafzali@thehlp.com.*

OCMS

Members in the News

To submit an item for OCMS Members in the News for future issues of the Bulletin, please email the item to Cindy Dady at cdady@msms.org or fax to (248) 773-4004. Please include your name and contact information with your submission.

OBITUARIES

OCMS would like to express our sincere condolences to the families of the following members:

MERLE CHILDERS, MD passed away on December 28, 2011. Doctor Childers was a general surgeon who resided in Tempe, Arizona. He had been a member of OCMS since 1958.

ROY VAN COOLEY, JR., MD passed away on February 28, 2010. Doctor Cooley was a family medicine physician who devoted many hours serving such organizations as the Pontiac City Building Authority, Oakland County Board of Supervisors, and the Boys and Girls Club of Pontiac. He was a resident of Pontiac and had been a member of OCMS since 1947.

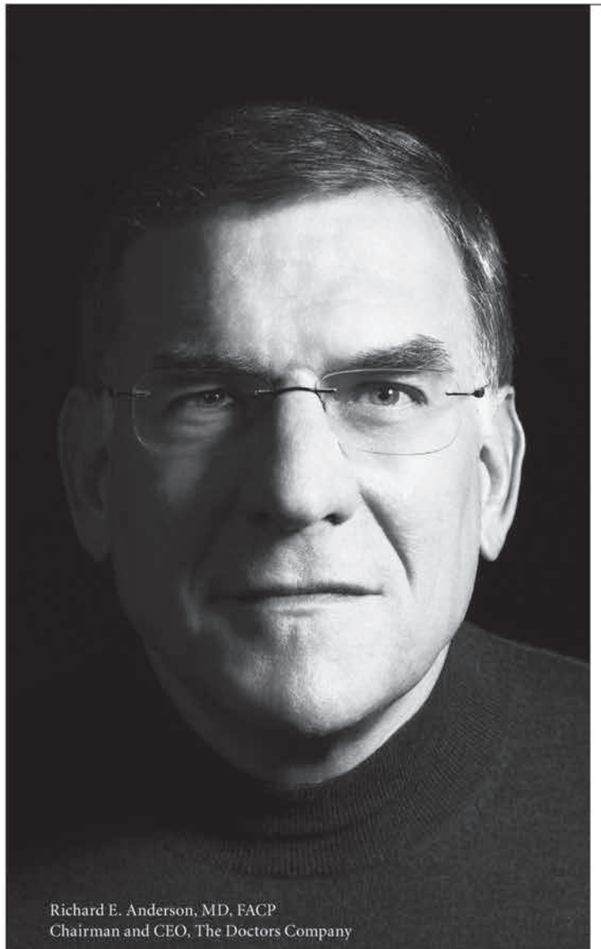
SIDNEY KATZ, MD passed away on September 26, 2011. Doctor Katz was an obstetrician/gynecologist who resided in Bloomfield Hills. He had been a member of OCMS since 1959.

IRVING LEVITT, MD passed away on September 2, 2011. Doctor Levitt was a pediatrician who resided in Atlanta, Georgia. He had been a member of OCMS since 1977.

GORDON S. MUSICK, MD passed away on March 24, 2011. Doctor Musick was a radiologist who resided in Kissimmee, Florida. He had been a member of OCMS since 1966.

CHARLES R. SEMPERE, MD passed away on January 15, 2012. Doctor Sempere was an obstetrician/gynecologist who held the positions of Chief of Staff, Medical Director, and Chair of the OB/GYN Department at Pontiac General Hospital during the course of his career. He had currently lived in Florence, Wisconsin but was formerly of Pontiac. He had been a member of OCMS since 1953.

Figure 6 *Anatomy of MSMS Physicians Insurance Agency*



Richard E. Anderson, MD, FACP
Chairman and CEO, The Doctors Company

We reward loyalty. We applaud dedication. We believe doctors deserve more than a little gratitude. We do what no other insurer does. We proudly present the Tribute® Plan. We honor years spent practicing good medicine. We salute a great career. We give a standing ovation. We are your biggest fans. We are The Doctors Company.

You deserve more than a little gratitude for a career spent practicing good medicine. That's why The Doctors Company created the Tribute Plan. This one-of-a-kind benefit provides our long-term members with a significant financial reward when they leave medicine. How significant? Think "new car." Or maybe "vacation home." Now that's a fitting tribute. The Michigan State Medical Society exclusively endorses our medical professional liability program, and we are a preferred partner of the Michigan Osteopathic Association. To learn more about our program benefits, including the Tribute Plan, call our East Lansing office at (800) 748-0465 or visit www.thedoctors.com/tribute.

THE DOCTORS COMPANY

www.thedoctors.com

Any Tribute Plan projections shown here are not intended to be a forecast of future events or a guarantee of future balance amounts. For a more complete description of the Tribute Plan, see our Frequently Asked Questions at www.thedoctors.com/tributefaq.