Second Quarter 2011

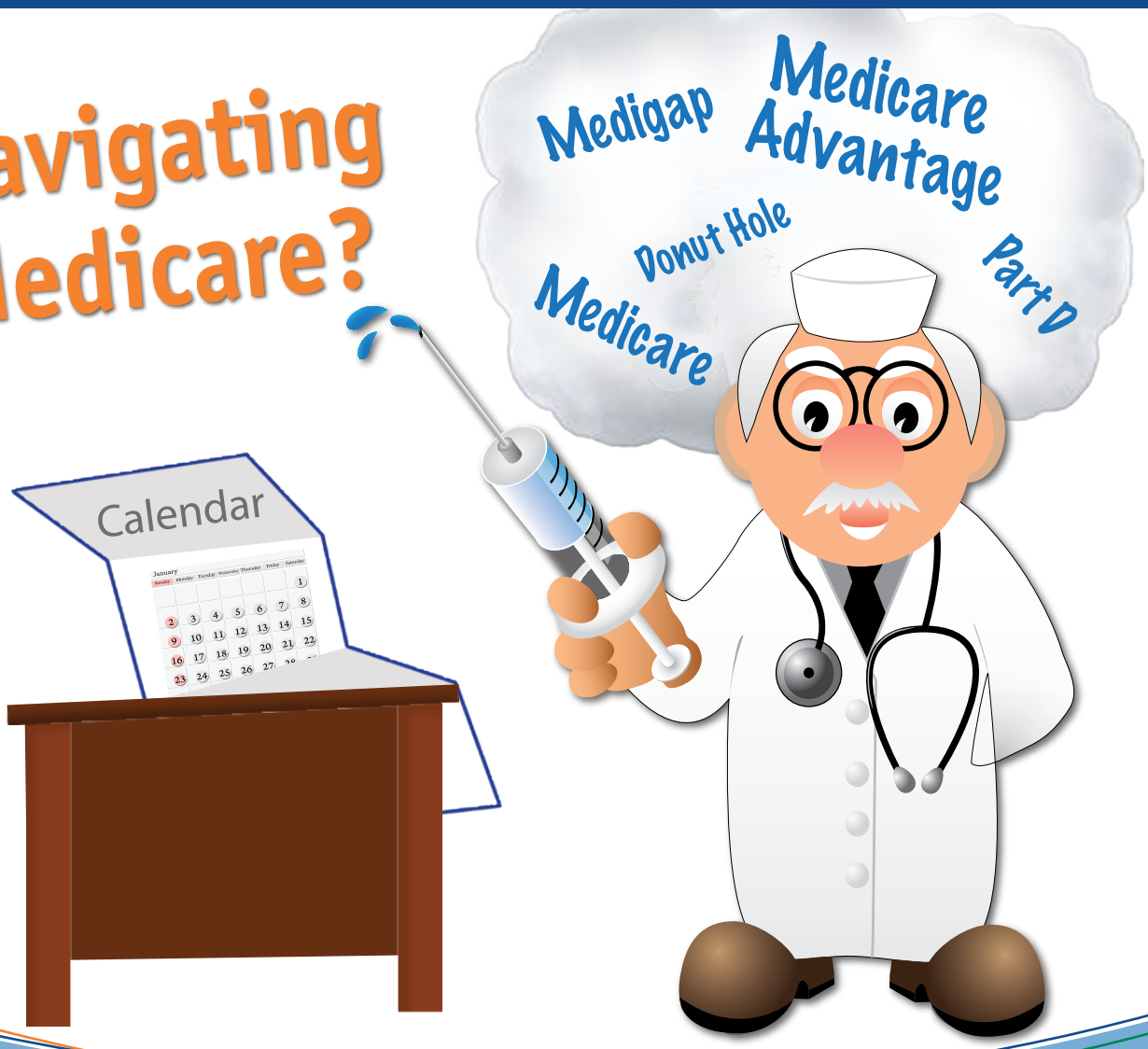
BULLETIN

House Adopts KCMS Resolutions

The Official Journal of the
Kent County Medical Society and the Kent County Osteopathic Association

Let PIA Clear the Air!

Navigating Medicare?



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MICHIGAN STATE MEDICAL SOCIETY
Physicians Insurance Agency

Second Quarter 2011 volume 96, no.2

BULLETIN

The Official Journal of the
Kent County Medical Society and the Kent County Osteopathic Association

KCMS

FEATURES/DEPARTMENTS

KCOA

ON THE COVER

Gregory J. Forzley, MD
Top Inset (l to r): Paul Farr, MD and MSMS President Steven E. Newman, MD
Bottom Inset: Rose Ramirez, MD

ABOUT THE BULLETIN

Editor - David M. Krhovsky, MD

The Bulletin is published four times yearly by the Kent County Medical Society and Kent County Osteopathic Association.

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WELCOME

NEW MEMBERS

Scott H. Greenwald, MD
Michigan Pain Consultants, PC

Daniel L. Maison, MD
Spectrum Health Palliative Care

RESIDENTS

Iain Chanley, MD

Viet Do, MD

MEDICAL STUDENTS

Brad Burmeister

Kyle Lineberry

IN MEMORIAM

Laird E. Hamstra, MD **1939 - 2011**

Laird E. Hamstra, MD, a retired member of the Kent County Medical Society passed away March 16, 2011. Doctor Hamstra received his medical degree from Northwestern University Medical School in 1964. He completed his internship at Blodgett Hospital, served as a Captain and General Duty Officer in the U. S. Army. He completed his Internal Medicine Residency at the University of Minnesota Medical Center. For the next 34 years he practiced Internal Medicine with Western Michigan Internal Medicine Associates before retiring in 2003.

Perry W. Greene, Jr., MD **1930 - 2011**

Perry W. Greene, Jr., MD, a retired member of the Kent County Medical Society passed away April 4, 2011. Doctor Greene received his medical degree from Wayne State University College of Medicine in 1955. He completed his internship and residency at Blodgett Hospital, 1955 to 1961. He served as a Captain in the U. S. Army from 1956 to 1958. He was an Orthopaedic Surgeon for 47 years and a founding delegate of the American Orthopaedic Sports Medicine Society. Doctor Greene served at KCMS Board President in 1974. He retired in 1995.

The Medical Society extends sympathy to both families.

MSMS COMMITTEES SEEK YOUR INVOLVEMENT

Committees on Aging, Bioethics, CME Accreditation, CME Programming, Information Technology, Maternal and Perinatal Health, Medical Licensure and Discipline, Membership Recruitment and Retention, State Legislation and Regulations and other committees need your help.

MSMS welcomes KCMS members to serve on their committees and task forces. If you are interested, contact the KCMS office at 458-4157 or e-mail kcmsoffice@kcms.org.

CHECK OUT OUR WEBSITE **KCMS.org**

DOCTORS IN THE NEWS

Dr. Peggy Thompson of GR Medical Education Partners led the celebration of the Michigan State University College of Human Medicine Match Day held on March 17.

Mentioned in *THE GRAND RAPIDS PRESS* Health Section:

Thomas Gribbin, MD was quoted in an article on "Cancer Confusion," an article discussing the trouble newly diagnosed cancer patients have trying to learn from different sources about their disease.

Martin Luchtefeld, MD discussed the need for early screening for colon cancer especially in the over-50 age group. Early screening is helping reduce the incidence of colon cancer.

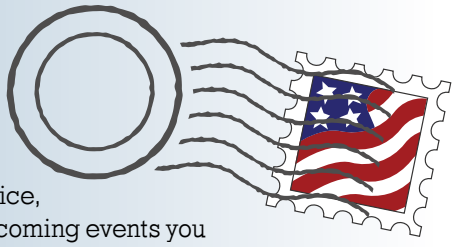
Andrea VanPelt, MD was in a Profile in Better Health section showing how she puts a priority on living a healthier life.

Robert Rood, MD discussed how millions are affected by Diabetes and how important early diagnosis and treatment is.

Dr. Paul Farr was featured outlining the health benefits of Colonoscopy tests and **Drs. Thomas Gribbin, Thomas H. Peterson** and **Paul Kemmeter** were featured in an article on the Obesity epidemic.

Bruce Baker, MD talked about drug testing helping firms provide safer workplaces. He discussed privacy versus safety and how testing can help avert calamities by bringing help to those who need it.

Did you know?
The KCMS office can assist your office team in mailings that promote your practice, a new partner or upcoming events you want to share with your KCMS colleagues. Contact the office at 616-458-4157 or kcmsoffice@kcms.org to learn more about how the Society staff can assist you.



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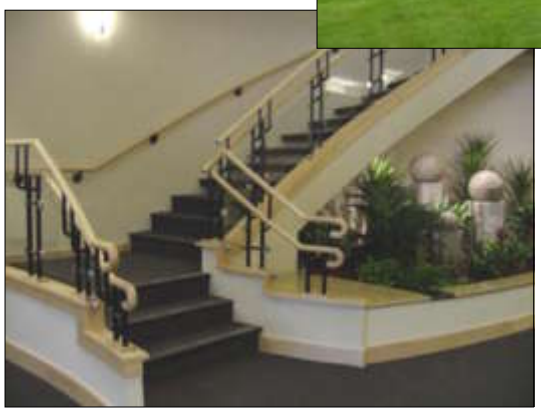

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PRESIDENT'S MESSAGE

Connecting and Communicating with Physicians

Gregory J. Forzley, MD
KCMS President

"Communicating is easy." Or is it? How many times have you found yourself saying "I don't know why they just don't understand, I sent them an email?" or "I should give them a call" or "they never tell me anything?" These are just some examples of how we misunderstand the difference between connecting and communicating. There are so many ways we can communicate today – email, cell phone, text messaging, Twitter, Facebook, television, blogs, YouTube, postal mail, the ever increasing number of magazines, newsletters and newspaper available both in print and online... the list goes on and on. But has the explosion in the ways we can communicate actually undermined our ability to ***effectively*** communicate? Since the start of my year as Kent County Medical Society president just a short time ago, I have been focused on the challenges we face as individuals, and as professionals, to wade through the massive amounts of information coming our way everyday in order to understand their importance. This issue begins the first in a series of four articles on connecting and communicating. Each article will have a different focus. This first article focuses on colleagues and other health professionals. The remaining three articles in the series will look at connecting and communicating with leaders and public officials, connecting and communicating with patients, and concluding with a focus on connecting with self and family.

"So Mr. Harris, why are you here today?" "Dr. Jeffries, my primary care physician, said I needed to see you because of this pain I have in my knee. She did some x-rays and said I should see you." "Oh really, I didn't get anything from her – did she send anything with you?" "No, she said she was sending you a letter." "Well, I haven't received anything – so what can you tell me about your problem?"... This simple interaction is an all too common occurrence in our profession. The patient has one idea of why they need to be seen, the receiving physician gets a different story than intended by the referring physician, and the patient may end up with the original question unanswered on the initial referral. Or the reverse happens when the primary care physician does not get timely information back from the referral physician. Either way, there is an opportunity for missed communication.

This gap in information was the focus of two recent reports. The first comes from the January 10, 2011 issue of Archives of Internal Medicine, *"Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground"* by O'Malley and Reschovsky. In that report, *"69.3% of PCPs reported "always" or "most of the time" sending notification of a patient's history and reason for consultation to specialists, but only 34.8% of specialists said they "always" or "most of the time" received such notification. Similarly, 80.6% of specialists said they "always" or "most of the time" send consultation results to the referring PCP, but only 62.2% of PCPs said they received such information. Physicians who did not receive timely communication regarding referrals and consultations were more likely to report that their ability to provide high-quality care was threatened."*

A similar report in February in an NIHCR research brief by Carrier, Yee, and Holzwart focused on *"Coordination Between Emergency and Primary Care Physicians"*. The authors reported that haphazard communication and poor coordination often exist, with resultant undermining of effective care through duplicative treatment and misapplied treatment. They suggest that *"correcting these discontinuities may require a much broader commitment to interoperable information technology, investments in care coordination and malpractice liability reform."*

The mainstays of our profession are the accurate and timely receipt of relevant information and a comprehensive evaluation of the patient's condition. It is imperative that we continuously strive to provide better information relevant to the care of the patient to our colleagues in the most efficient manner possible. This may mean a timely phone call, secure information transmission using the plethora of modern tools available to us or something as traditional as a 'curbside consult' with a colleague at a professional gathering or the hospital hallways. Whatever the method, for the benefit of the patient it is crucial that we make this important connection as regular and automatic in our processes of care as we can.

But there is another valued aspect of our communicating and connecting with our professional colleagues – that of genuine relationship building and engagement with our peers. Our opportunities to connect with our colleagues in a non-medical setting have often been conveniently scheduled for us only

within our larger groups that now dominate the greater Grand Rapids area. While those interactions are important in order to develop a sense of community within the group, it is also important to step outside our own group and cross the boundaries of collegiality within our broader professional community. Such simple actions as attending the annual medical staff meeting, or the medical society meeting or other professional event where there is time set aside for social interaction will be the first of many steps toward broadening professional relationships and camaraderie within the West Michigan professional circle. All of these opportunities will build relationships, broaden understanding of our profession and the shared challenges that we face, all the while strengthening the "house of medicine".

As you might expect, there are many additional important forms of professional communication focused on patient care and other health professionals that would be difficult to address appropriately in a short review. These include handoff communications from one clinician to another, where the use of SBAR (Situation-Background-Assessment-Recommendation) has become a commonly used format for that purpose. Another significant form of communication surrounds the development of patient care teams, especially highlighted by the prominence of the patient-centered medical home, where effective *connection* and leadership play a central role.

All together, the potential gaps mentioned here point to the need for all of us to continuously focus on the importance of not just giving information in one form or another, but making the connection in a truly meaningful way. Some of us are skilled in this, and should take the lead in mentoring others. Others of us need coaching, encouragement, and simply need to be "asked" to take the first steps to getting connected. So what will you do today to make that connection?

KCMS

KCMS DELEGATES SENT 30 RESOLUTIONS TO THE MSMS HOUSE OF DELEGATES:

They are listed below along with their results.

Summary of Submitted Resolutions:
30 Resolutions Submitted
12 Adopted
8 Adopted as Amended
4 Refer to Board
5 No Action
1 Disapprove

MICHIGAN STATE MEDICAL SOCIETY

The following resolutions were introduced by Domenic R. Federico, MD for the Kent County Delegation.

RESOLUTION 50-11

By: Brian A. Roelof, MD
Title: Clear Identification of Health Worker Position/Title with ID Tags.
Adopted.
RESOLVED: That MSMS seek legislation to require that physicians, nurses and other health providers wear a clearly visible photo identification badge that states their credentials in large block letters with descriptions such as "physician", "nurse", "physician assistant", nurse practitioner", and that the badges be worn at all times when in contact with patients.
RESOLVED: That MSMS advocate that health systems design and utilize different color ID badges for the different classifications of providers
RATIONALE: Whereas Resolution 15-11 encompassed a broad range of topics and used terminology that left the Committee unsure of the author's intent, Resolution 50-11 defines credentials and is limited to identification requirements within health system facilities. The Committee preferred this resolution as it addresses an important aspect of transparency and disclosure in health care settings. And while the Committee had some reservations about how much this would improve confusion among patients and reducing improper communication by lesser trained professionals, the Committee believes that the patients should have the right to know the type of professional treating them.

RESOLUTION 51-11

By: Brian A. Roelof, MD
Title: Inclusion of Professional Title and License Type in Advertising.
Adopted.
RESOLVED: That MSMS seek legislation to require that all health care advertising include the professional title and license type.

RESOLUTION 52-11

By: Jayne E. Courts, MD
Title: High School Athletics Physical Examination Requirement.
Adopted as Amended.
RESOLVED: That MSMS work with Michigan High School Athletic Association (MHSAA) to consider changing the current guideline to allow a sports physical examination within the past year before beginning a sport season to better meet the MHSAA Student Athletes, Families, and Physicians; be it further
RESOLVED: That MSMS works actively with AAP, ACP, AAFP, and other interested organizations to further promote and advocate for the desired changes.
RATIONALE: The major issue concerning this resolution was the deadline that was given to submit the sports physical forms to the schools is April 15. This creates a situation where multiple physicals can be completed in one year and payers might not cover the costs of the physical. Also, testimony was offered that this creates an overuse of the athlete's, family and physician's time by having to continually receive a physical. The members of the Committee believed that if a physical was completed within the last calendar year, it should be good for the entire calendar year, i.e. if the physical was completed in March it would be good until January of the following year. The members hoped that bringing together all of the interested groups to advocate MHSAA and be a visible part in the discussion of hopeful change.

RESOLUTION 53-11

By: Jayne E. Courts, MD
Title: CMS Guidelines and Homes for the Aged – LPN Scope of Practice.
Adopted.
RESOLVED: That MSMS encourage Center for Medicare and Medicaid Services to allow the receipt of verbal orders in Homes for the Aged that employ licensed practical nurses so that appropriate care may be provided in a more expeditious manner; and be it further
RESOLVED: That MSMS ask Center for Medicare and Medicaid Services to change guideline R325.1932 to clearly allow receipt for verbal orders as the CMS surveyors currently vary their own interpretation of this guideline which makes the Home for the Aged facilities vulnerable to unfair citations.
RATIONALE: The Committee could not justify the current rules that limit the ability of physicians to issue verbal orders in some settings but not others. The rule in question appears to be arbitrary and unnecessary and simply adds an administrative burden for physicians.

RESOLUTION 54-11

By: Jayne E. Courts, MD
Title: Formulary Changes in the Technological Era.
Adopted as Amended.
RESOLVED: That MSMS ask the Michigan Health Insurance Commissioner to require all health insurance companies to provide easy access to their formularies via all forms of communications including the health insurance company's web site which can be accessed by patients, pharmacists, and physicians and to include the acceptable formulary alternative medications with any mailed/faxed information about formulary changes.

RESOLUTION 55-11

By: Jayne E. Courts, MD
Title: Prior Authorization in the Technological Age.
Adopted as Amended.
RESOLVED: That MSMS ask the Michigan Health Insurance Commissioner to require all health insurance companies and/or pharmaceutical benefit managers to include the appropriate prior authorization forms with the faxed notification and/or to include a web address where prior authorization forms may be easily accessed by the physician; and be it further
RESOLVED: That MSMS ask the Michigan Health Insurance Commissioner to work with health insurance companies and pharmacy benefit managers to develop simple prior authorization forms which will be used uniformly by all of the health insurance companies and pharmacy benefit managers in this state.

RESOLUTION 56-11

By: Jayne E. Courts, MD
Title: Mozelle Senior Medical Alert Act.
Adopted.
RESOLVED: That MSMS support legislation that would allow utilization of the Amber Alert system for missing senior citizens.
RATIONALE: The Committee was provided with an example of the effectiveness of the Amber Alert system in locating missing children. Additionally, the Committee heard examples of potential situations involving seniors that would benefit from a similar statewide alert. To the extent that this program could be initiated without diminishing the effectiveness of the Amber Alert System for children, the Committee was supportive of this resolution.

RESOLUTION 57-11

By: Yvan Tran, MD
Title: Driving Recommendations in Patients with Epilepsy.
Adopted.
RESOLVED: That MSMS ask for legislation that will provide physicians with protection from any civil or criminal liability for their opinion and recommendations to the Michigan Secretary of State; and be it further
RESOLVED: That MSMS work with the state legislature to provide physicians protection from civil or criminal liability for accidents in which seizures or loss of consciousness occur.
RATIONALE: This resolution is very similar to resolutions that have been brought before the House in the past. Additionally, the Committee heard testimony from physicians who were actively involved in the recent legislative attempts to pass bill that addresses the concerns of this resolution. This issue remains a priority for MSMS.

RESOLUTION 58-11

By: Yvan Tran, MD
Title: HIPAA Relief for Physicians Caring for Patients with Loss of Consciousness and Seizure Disorders.
Referred to the Board for Study.
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with the appropriate federal agencies to allow physicians to report episodes of seizures or loss of consciousness without HIPAA liability. RESOLUTION 50-10A.
RATIONALE: Due to an existing exception under HIPAA for reporting events to avert a serious threat to safety or health to the person or entity that could reasonably prevent or lesson harm, a lack of protection under state confidentiality laws, and the introduction of legislation (Senate Bill 111) by the Michigan Senate, the Committee believes that further Board study was the most appropriate recommendation.

RESOLUTION 59-11

By: Gilbert D.A. Padula, MD
Title: Cell Phone Ban while Driving in Michigan.
Adopted as Amended.
RESOLVED: That MSMS ask the AMA to work with the National Highway Traffic Safety Administration (NHTSA) to initiate policies and programs to incentivize states to reduce the occurrence of distracted driving, and be it further
RESOLVED: That MSMS seek state legislation to mandate a hands free or Bluetooth device when using a cell phones while driving.
RATIONALE: The Committee was informed that the AMA already adopted a policy in 2009 that seeks to require hands free devices. However, MSMS has no such policy internally. Therefore, the Committee recommends the first resolved which provides consistency between the positions of MSMS and the AMA. The Committee also believed that as new data regarding distracted driving emerges, it will point toward policies designed to address this issue. The Committee discussed the positive role that NHTSA has had in encouraging seat belt and children's car seat laws, as well as the negative impact of Congress limiting the role of NHTSA in incentivizing motorcycle helmet laws. The Committee envisions NHTSA taking a leadership role in incentivizing states to adopt laws regarding distracted driving consistent with their findings within the available data.

RESOLUTION 60-11

By: David M. Reifler
Title: Exhibition of Plasticized Bodies Without Known Informed Consent Status.
Adopted as Amended.
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to thoroughly investigate the source of the bodies for the Premier Exhibition, Inc.'s, Bodies Revealed exhibits, possibly with the assistance of the United States Department of State.
RATIONALE: The Committee heard testimony about the concerns some physicians have about how the bodies in the Bodies Revealed exhibits were obtained, about the exhibiting company paying the Chinese government for the bodies, and that there are no specific answers given by the exhibit company about these issues.

RESOLUTION 61-11
By: David W. Whalen, MD
Title: Gross Negligence Standard for EMTALA Related Care.
Adopted.
RESOLVED: That the MSMS seek legislation that would require a standard of gross negligence on all Emergency Medical Treatment and Active Labor Act related care.
RATIONALE: This resolution is very similar to resolutions that have been brought before the House in the past. Additionally, the Committee heard testimony from physicians who were actively involved in the recent legislative attempts to pass bill that addresses the concerns of this resolution. This issue remains a priority for MSMS.

RESOLUTION 62-11
By: Donald P. Condit, MD, MBA
Title: Providers Promoting Medical Marihuana Registry Identification Cards.
Adopted.
RESOLVED: That the MSMS work with elected officials in the state of Michigan to define a bona fide doctor-patient relationship in order to protect the public from harm from providers promoting Medical Marihuana Registry Identification Cards.
RATIONALE: The consensus of the Committee and those who testified on this resolution is that Michigan has a very bad law relating to Medical Marijuana. Additionally, there is widespread frustration among physicians over the very small number of physicians who are responsible for certifying the vast majority of the 100,000 patients that have submitted certifications to the state of Michigan. This resolution has the potential to provide physicians with an opportunity to weigh in on key oversight under the Medical Marijuana Act and provide regulators with the necessary tools to curtail the mass screenings that currently take place and result in many certifications of questionable validity.

RESOLUTION 63-11
By: Donald P. Condit, MD, MBA
Title: Taxpayer Funding of Abortion.
Referred to the Board for Study.
RESOLVED: That MSMS delete the pre-1990 Policy on Medicaid Funding of Abortions, which states "The state of Michigan should fund abortions for Medicaid patients."
RATIONALE: The Committee heard extensive testimony from proponents on both sides of the abortion issue. Issues of patient safety and financial issues also were discussed. The Committee felt that MSMS should be tolerant of the diverse beliefs and positions of its members and potential members. The Committee agreed that this issue and other older policies in the MSMS Policy Manual annotated with "Prior to 1990" should be reviewed by the MSMS Board of Directors to determine if any are out-of-date and should be removed or amended.

RESOLUTION 64-11
By: Susan Wakefield, MD
Title: Pharmacy Response Time to e-Prescriptions.
No Action.
RESOLVED: That MSMS urge the Michigan Pharmacists Association and the Michigan Board of Pharmacy to communicate to pharmacies about the importance of timely response to prescriptions that are e-prescribed by Michigan physicians.
RATIONALE: While the Committee understood the motivation behind the resolution, the Committee felt that this was really a customer satisfaction issue and action would interfere with free commerce.

RESOLUTION 65-11
By: Michelle M. Condon, MD
Title: Move Tramadol to Schedule 2 Drug Designation.
Referred to the Board for Study.
RESOLVED: That MSMS ask the Drug Enforcement Administration (DEA), to reclassify tramadol as Schedule 2, and be it further
RESOLVED: That the Michigan Delegation of the AMA ask the AMA to ask the Drug Enforcement Administration to support its efforts.
RATIONALE: Although the Committee agreed with the spirit of the resolution, they determined that making amendments to it may alter the author's intent. The Committee would encourage the author to revisit the issue and submit a new resolution that clarifies her ultimate goal.

RESOLUTION 66-11
By: Michelle M. Condon, MD
Title: Ban E-Cigarettes from Public Venues.
Adopted as Amended.
RESOLVED: That MSMS oppose the use of e-cigarettes in public places and advise the Michigan legislature of its opposition; be it further
RESOLVED: MSMS seek legislation to place use of e-cigarettes in the Michigan Smoke-Free Act.
RATIONALE: The Committee had spirited discussion and debate concerning the use of e-cigarettes and the dangers that they pose. The AMA Advisors brought forth a report by the AMA that discussed the potential dangers using e-cigarettes may contain. The amount of chemicals including nicotine are not measured or tested to know the true amounts. The amount of harmful chemicals in e-cigarettes have been shown to fluctuate, but do not emit smoke in the public endangering those around the smoker. Suggestions were brought to the Committee that the use of e-cigarettes was helpful in smoking cessation, but were rebuked by the AMA report that was presented by the AMA Advisors. The Committee believed that this issue will continue to be a topic of interest for years to come. Finally, the Committee debated the rights of the individual to use such a product, if of age, in a public setting. Some members felt that since the harm of the device was only limited to the individual themselves and not those around them it should be justified to be used by the person. Other members believed that the use alone is harmful to anyone and therefore the use should not be permitted.

RESOLUTION 67-11
By: Michelle M. Condon, MD
Title: Require Federally-funded Health Centers to Participate in Prescription Assistance Programs (PAP).
No Action.
RESOLVED: That MSMS request the legislature insist that federally-funded community health centers be required to participate in prescription assistance programs as needed by their uninsured patients; and be it further
RESOLVED: That MSMS Delegation to the AMA request that the AMA pursue congressional action to require federally-funded community health centers to participate in prescription assistance programs as needed by their uninsured patients.
RATIONALE: The Committee did not believe it was appropriate for MSMS to mandate that Federally Qualified Health Centers participate in prescription assistance programs. Physicians, regardless of practice location, need to be able to determine their ability to comply with program requirements. This appears to be an issue that could be addressed by working with the local stakeholders.

RESOLUTION 68-11
By: Michelle M. Condon, MD
Title: Prohibit Ambulance Companies from Presenting Blank Screens for Physician Signature.
No Action.
RESOLVED: That MSMS work with the Michigan Department of Community Health and other appropriate state agencies to amend the practice of asking physicians to sign a blank EMR screen for paramedic records so that physician signature is meaningful and legally appropriate without frustrating our paramedic partners.
RATIONALE: The Committee believes it is incumbent upon physicians to know what they sign before it is signed. Additionally, there is no evidence indicating that physicians are required to sign a blank EMR screen.

RESOLUTION 69-11
By: Michelle M. Condon, MD
Title: Credentialing Limit Ability to Provide the Certification Needed to apply for a Medical Marihuana Registration Card to the Patient's Pain Medication Physician.
Disapproved.
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with the Joint Commission and other accrediting organizations to establish suitable criteria for privileging primary care physicians to treat medical patients at hospitals even if their total number of patient admissions falls below a particular threshold in a year, with a report back in 2011.
RATIONALE: The Committee agrees with the intent of this resolution, but prefers the approach taken in Resolution 62-11. The elements of the physician patient relationship highlighted in this resolution will certainly be part of the deliberations of what constitutes a bona fide relationship between a physician and patient as well as other aspects not specified in Resolution 69-11. Because Resolution 62-11 specifies only that MSMS work to define the relationship between a patient and certifying physician, it has the potential to be a more comprehensive approach to solving this problem.

RESOLUTION 70-11
By: Michelle M. Condon, MD
Title: Cost and Availability of Insulin.
Adopted as Amended.
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with the American Diabetes Association and Juvenile Diabetes Research Foundation and other appropriate organizations to investigate the best methods to address the high cost and availability of insulin for uninsured and underinsured patients with diabetes.
RATIONALE: The Committee heard testimony from the author and others about how the cost and availability of insulin is negatively affecting how patients manage their diabetes care.

RESOLUTION 71-11
By: Susan Wakefield, MD
Title: Lack of Access to Dental Care.
Adopted.
Adopted as Amended.
RESOLVED: That MSMS begin dialogue with the Michigan Dental Association, the Michigan Academy of Pediatric Dentistry and the MDCH to increase dental access and care for patients with Medicaid and for patients with no health care insurance who cannot access affordable dental care.

CONTINUED ON PAGE 12

RESOLUTIONS *(CONTINUED FROM PAGE 11)*

RESOLUTION 72-11
By: John vanSchagen, MD
Title: Physician Re-entry.
Adopted as Amended
RESOLVED: That the MSMS Board of Directors work with our state medical licensing boards to develop physician re-entry policy guidelines that are clear and consistent; and be it further
RESOLVED: That the MSMS Board of Directors work with our state medical licensing boards to develop and validate a process for previously board-certified physicians to participate in re-entry training necessary to return to their original scope of clinical practice; and be it further
RESOLVED: That MSMS work with our state medical licensing boards to develop physician re-entry policy guidelines that are clear and consistent; and be it further
RATIONALE: The Committee amended the first resolved portion to delete the phrase "previously board-certified" to broaden the intent of the resolution. The author of the resolution accepted this as a friendly amendment.

RESOLUTION 73-11
By: Eric Larson, MD
Title: Requiring Patients with HSAs to obtain Prescriptions for Over-The-Counter Medications and Basic Medical Supplies.
Adopted.
RESOLVED: That the Michigan Delegation to the AMA asks the AMA to work to rescind the new regulations that require patients with health savings accounts to obtain prescriptions for over-the-counter medications and basic medical supplies.
RATIONALE: The Committee agrees with the intent of this resolution to allow patients to purchase over the counter medications and basic medical supplies without a prescription. Furthermore, there were no dissenting comments during testimony.

RESOLUTION 74-11
By: Patrick J. Droste, MS, MD
Title: Vision Screening Programs for Children.
Adopted.
RESOLVED: That MSMS urge state and county governments to continue to support the development of effective vision screening programs for pre-school and school age children; and be it further
RESOLVED: That MSMS encourage county and state governments to continue financial support to maintain and improve vision screening programs for pre-school and school age children.

RESOLUTION 75-11
By: Michelle M. Condon, MD
Title: Confirmation of Federally Qualified Health Centers (FQHCs) Compliance with Federal Guidelines.
No Action.
RESOLVED: That MSMS investigate current patient complaints regarding Michigan's FQHCs that receive federal support because of multiple reports of patients without insurance being refused care; and be it further
RESOLVED: That MSMS request that the Michigan Department of Community Health and the appropriate federal agencies evaluate the current practices of FQHCs in terms of meeting their mission to serve community needs; and be it further
RESOLVED: That MSMS advocate that FQHC organizations that bus or transport illegal or undocumented individuals to other health centers for them to receive care be forced to discontinue the practice or lose their FQHC status; and be it further
RESOLVED: That MSMS advocate that patients of FQHCs be given 30 days notice, similar to private physician offices, if relationships with patients are to be discontinued due to the patient's inability to pay and documented non-compensation of existing, prior charges.
RATIONALE: While the Committee does not condone the events described in the resolution, the Committee believes this to be a local aberration which should be addressed through appropriate channels. Additionally, Committee members do not believe MSMS is the proper organization to address this issue. Again, this appears to be an issue that could be resolved by local stakeholders working with their local Federally Qualified Health Centers as needed.

RESOLUTION 76-11
By: Patrick J. Droste, MS, MD
Title: Untimely Insurance Audit Payment Recovery.
Adopted.
RATIONALE: This resolution is very similar to 44-11. The rationale for support is identical.

RESOLUTION 77-11
By: Patrick J. Droste, MS, MD
Title: Exemption of Release of Co-pay Obligations When Children's Special Health Care Services (CSHCS), Michigan Medicaid or Michigan Medicaid Product is the Secondary Insurance.
Referred to the Board for Study.
RESOLVED: That MSMS ask for legislation that would require collection of co-pay at time of services for all plans that require co-pay prior to billing primary and secondary insurances.
RATIONALE: The Committee did not have enough information to make a recommendation of approval or disapproval as there are several issues involved with the coordination of benefits that require a more thorough review of potential action within MSMS's purview.

RESOLUTION 79-11
By: Patrick J. Droste, MS, MD
Title: Non-payment of "Authorized" Medical Services.
Adopted.
RESOLVED: That MSMS work for legislation that provides for all of the following:
1. Authorization for specific service(s) is associated with payment for services rendered.
2. Reimbursement for services rendered is received within 30 days.
3. Services with "authorization" cannot be denied retrospectively with request for return payment.

RATIONALE: All of the members of the Committee had firsthand knowledge of the practice of insurers improperly withholding payment by retroactively denying payment for services that were prior authorized. The prevalence of this practice by insurers was troubling to the Committee and reinforced the need for MSMS to take action on this issue.

RESOLUTION 81-11
By: Patrick J. Droste, MS, MD and Deborah M. Droste, RN, BSN
Title: Establishment of Objective Criteria to Monitor and Approve 'For Profit' and 'Non-Profit' Insurance Carriers Premium Rate Increases.
Referred to the Board for Study.
RESOLVED: That MSMS work for legislation, or work with Michigan's Insurance Commissioner, to do all of the following:
1. Initiate limits on insurance carrier rate increases based on objective criteria.
2. Provide that 'For Profit' and 'Non-Profit' insurance carriers identify the costs per dollar for direct health care per premium dollar.
3. Require that insurance carriers must allocated greater than 70% of each premium dollar toward direct health care costs.

RATIONALE: On the surface, this resolution appears to require accountability among insurers by mandating that a minimal amount of money go toward the Medical Loss Ratio, and that rate increases receive greater scrutiny by regulators. However, the result of some of the specific elements of this resolution could disproportionately help certain insurers in Michigan while at the same time limiting competition among other insurers. The Committee did not want to simply dismiss this resolution because these questions should be asked and answered. However, the technical nature of these questions did not lend themselves to being resolved by the Committee. Further study on this matter is required.

50 Years in Practice

Pictured above (l to r): **James Irwin, MD, Joseph Marogil, MD, William Passinault, MD, Miles Murphy, MD, Judy Meyer, MD, Paul Clodfelder, MD, Henry Guzzo, MD, and Jack Carr, MD**

The following physicians were the recipients of the MSMS award for having graduated from Medical School in 1961, 50 years ago. They were celebrated with a luncheon at the House of Delegates meeting in Kalamazoo as well as recognition which was given to them at the May meeting of the Kent County Medical Society. It is with great pleasure that we celebrate the contributions of dedication to their discipline, training of new physicians and generosity to the patients of:

Graham M. Barnett, MD
Jack N. Carr, MD
R. Paul Clodfelder, MD
Mario D. Gatchalian, MD
Leonard S. Gell, MD
Henry V. Guzzo, MD
James R. Irwin, MD
Joseph B. Marogil, MD
Judith L. Meyer, MD
Miles J. Murphy, MD
William J. Passinault, MD
John C. Rienstra, MD
Michael K. Tay, MD
Thomas A. Weeber, MD

Congratulations

KENT MEDICAL FOUNDATION

Patrick J. Droste, MS, MD
KMF Board Chair

RECENT ACTIVITIES FUNDED BY KMF

nicoTEAM Tobacco Prevention Program

(Pictured right) The award-winning student-designed poster for the nicoTEAM Tobacco Prevention Program sponsored by the Kent Medical Foundation and UnitedHealth Care. The awards ceremony took place at the Grand Rapids Art Museum and was featured in *THE GRAND RAPIDS PRESS*.

Cooking with KMF

(Pictured left) MSU medical students launch Healthy Cooking, a project funded by the Kent Medical Foundation encouraging local families to improve their health, one healthy home-cooked meal at a time.

Kent Medical Foundation Board welcomes newly elected Trustee, Margie Gerencer of Echelbarger, Himebaugh, Tamm & Co. P.C. (EHTC).

PROJECT ACCESS UPDATE

Eric Bouwens, MD
Board Chair
With special contribution by:
Case Manager
Pamela S. Wilson, RN, MM

Since 2006, Pam Wilson, RN, MM has served in the role of Case Manager, first as a volunteer for Project Access, then as an employee. Sadly, Pam will be retiring in June 2011. The Project Access Board and Staff are grateful for her years of service and compassion and wish her many happy and healthy years in retirement. Her contributions to the Project Access office have been significant and have enriched the lives of the many patients she has met, coached, and encouraged. Pam created a synopsis of her work with Project Access. What you see below is an excerpt of the many functions she provided for our small office. Her time and patience in unraveling a patient's medical history helped the Project Access office support the gift of care being shared by the Project Access volunteer physician.

My duties as a nurse case manager at Project Access change almost every day, and sometimes more than one time in a day, and may include:

• Interviewing many applicants who have stories of hardship and suffering, who expect to get donated care from Project Access. Many of these patients are unwilling to change behaviors, such as stop smoking, because they are "stressed". I may have to try several different approaches to find a way to convince them that choosing to do their part to get healthy is just as important as the donated care they are seeking.

• Fielding calls from total strangers who are demanding help, and if it is not given, threaten suicide. I may have to initiate a police welfare check for the caller's safety, only to deal with the same caller the next day who is now angry about the help that was sent , but still asking for more help.

• Contacting doctors' offices when the Project Access applicant has revealed, after detailed questioning, some medical issues that may be dangerous, such as getting similar medications from different doctors, not taking prescribed medications, using a friend's medications, or an undisclosed diagnosis for which a contra-indicated medication has been prescribed.

• Problem solving with a doctor who has a patient in the office who needs help. The doctor does not work with Project Access, but still needs ideas on what resources are available.

• Gathering information about new government programs, such as the Stimulus package of 2009 and Health Care Reform of March 2010, as well as how to navigate the various processes to enroll.

• Researching community resources and sharing them in various ways through our website, community speaking, and written materials given to anyone who calls on the intake line.

• Coordinating care from a variety of medical offices, disciplines, and agencies to get specialized care donated for a specific patient.

• Finding the most appropriate care, which may not be Project Access, such as COBRA subsidy, Medicaid, and health centers, since Project Access is temporary and used when other programs are not available.

• Listening to someone who is mentally ill and so distraught, frustrated, and angry, that they are threatening violence to others, and actually have a history of doing it. I may have to be a witness for temporary commitment for psychiatric care, if the person is unwilling to go voluntarily.

• Taking the time to answer questions no one else has answered for them previously, such as community navigation, explaining a medical test or procedure, and what is offered in the new health care bill.

• Offering information and suggestions related to unemployment, volunteerism, and retraining, that are not directly health related but have a huge impact on well being.

• Reviewing diabetic routines and self-management, and the importance of continuous management in preventing complications.

• Educating smokers about how to quit smoking rather than why they should, using Mayo Clinic's *Become an Ex* book.

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FEATURE

ALLIANCE HEARTBEAT

The Alliance advances the science and art of medicine in partnership with the Kent County Medical Society by advocating health-related philanthropy, legislation, education, and by promoting friendship among families of physicians.

President's Chat

Phyllis G. Rood
KCMS Alliance President

It is spring and therefore my term as your President is near its end. It has been an honor and a privilege to represent this organization in the various capacities required. We had tours of the DeVos Children's Hospital, Catherine's Health Care, and DA Blodgett /St. John's Home and learned how each served the children of Kent County.

Our fund raising efforts were very successful! We raised $62,000 for Catherine's Health Care, DA Blodgett, and our KCMSA foundation at the February Charity Ball. Also the April Steak and Lobster Sale/ Dinner profits were $1700 for our KCMSA foundation.

As I stated in the beginning, "it is spring", therefore it is membership renewal or joining new time. Join now, so we have you in the directory. This, we will have ready for the September meetings. I know Barbi Sink is preparing a year with informative meetings, opportunities to do volunteer service, and social times. If you have any questions about the KCMSA call me (456-5279), but join. This is a group of dedicated volunteers, committed to improving healthcare in Kent County. If you cannot be an active member, know your membership dollars are used to raise funds for our KCMSA foundation and charities that improve the lives of children and young people in Kent County. JOIN NOW!!

For more information go to the Alliance website at www.kcmsalliance.org

2011/2012 KCMSA Board

President **Barbara Sink**	Corresponding Secretary **Deborah Shumaker**
Immediate Past-President **Phyllis Rood**	Treasurer **Beth Junewick**
Recording Secretary **Kathy Kendall**	Assistant Treasurer **Andrea Haidle**

Spring Gathering THANK YOU!

Thank you, thank you, and thank you once again this year for giving so generously to the Spring Gathering in April for Judge Gardner's Closet! The day after Holly Jones and I dropped your donations at the Courthouse (yes, we did need more than one car to transport it all!), I received a call from Judge Gardner with her heartfelt thanks. She told me that quite literally, just the day before, the Closet was almost bare. And, like Mother Hubbard, she didn't quite know what she was going to do, especially as this seems to be the season in which many Wards of the Court move into Independent Living status. Our donations the next day were, in her words, "a miracle" and could not have been more timely or appreciated.

Judge Gardner told me that she of course will send a thank you note to the Alliance, but she said no note could ever convey her heartfelt thanks for our generosity, and she wanted to let me know that immediately...and I am trying to convey that to you with this message. I believe we are the only group that helps to fulfill this large need, so...once again...thank you for your kindness and your generosity. It does make a difference in the lives of very many young people here in Kent County.

Andrea Haidle, KCMSA Liaison for Judge Gardner's Closet

Doctors and Their Families *Make a Difference*

Personal care items for moms and babies, socks, hats and mittens, diapers and over the counter medications were collected again this year for Doctors and Their Families Make a Difference at the Holiday Tea. The members were most generous and many bags of supplies were taken to the YWCA Crisis Center just before Christmas. My trunk and back seat were full so thank you to all the members who donated.

Mary Crawford

PROJECT ACCESS UPDATE *(CONTINUED FROM PAGE 15)*

• Working with other case managers from refugee programs, hospital discharge planners, substance abuse rehab counselors, and mental health counselors who are transitioning their patients into the community.

• Thanking various doctors, staff, hospitals, and other providers in tangible ways for the difference they make in the lives of Project Access patients.

Annual Board Meeting

At the Annual Meeting of the Project Access Board, the following Officers and new Directors were elected:

Chair	**Eric Bouwens, MD**
Vice Chair	**Laura VanderMolen, DO**
Treasurer	**Donald Condit, MD, MBA**
Director	**Dorothy A. (Robin) Pedtke, DO**

The Project Access Board welcomes Scott Carlson, DO and Jennifer Hemingway, DO as new Board Members. The Board would also like to thank Davis L. Dalton, DO for his service, at the completion of two 3-year terms on the Project Access Board of Directors.

GRAND RAPIDS MEDICAL EDUCATION PARTNERS UPDATE

Interprofessional Education

Peter Coggan, MD, MSEd
GRMEP President and CEO

A recent report entitled "Core Competencies for Interprofessional Collaborative Practice" calls attention, again, to the need to change health professions education to meet the demands of the emerging healthcare system. The report, sponsored by the Interprofessional Education Collaborative, has wide support from organizations such as the Association of American Medical Colleges (AAMC), the American Association of Colleges of Nursing and the Association of Schools of Public Health. The report draws attention to the need to foster teamwork among the health professions which "requires shared knowledge of each participating member's roles and abilities. Without this acknowledgment, adverse outcomes may arise from a series of seemingly trivial errors that effective teamwork could have prevented." (Baker et al., 2005)

> **"No member of a crew is praised for rugged individuality of his rowing."**
> —Ralph Waldo Emerson

I was surprised to discover that the basic concepts of interprofessional education were outlined as long ago as 1972 in a report from the Institute of Medicine. With such a long history, and such an evident current need, why is it taking so long to change our education programs? The final few pages of the report list the reasons. The first is lack of senior administrative leadership. Others include a lack of potential partner professional schools with which to work; lack of appropriate faculty development to foster interprofessional education skills; and a need for assessment instruments to evaluate interprofessional knowledge and skills. When the resistance of faculty to the development of new curricula or the adaptation of existing curricula, and the often rigid and protectionist accreditation requirements imposed on programs by their specialty organizations are added to the list, it is easy to understand why necessary changes to accommodate interprofessional educational opportunities have been slow to occur.

The report, however, cites some striking examples of success. The Medical University of South Carolina has woven interprofessional education into its ten year quality enhancement program. Vanderbilt University is collaborating with two other universities to include pharmacy and social work students in training programs for medical and nursing students. UCSF and Rosalind Franklin University in Chicago are using a common calendar across programs. Western University of Health Sciences is explicitly training faculty in professional facilitation skills. In Canada, eight accrediting organizations supported by Health Canada have adopted shared principles and plan a pilot test of common program assessments to evaluate interprofessional education activities.

The interprofessional education program here in Grand Rapids, sponsored jointly by Grand Valley State University College of Health Professions, MSU College of Human Medicine and Grand Rapids Medical Education Partners has tapped into the resources of a number of the programs described above for our own interprofessional education initiative. Although we experience challenges implementing the changes identified in the "Core Competencies" report, we have excellent support from the universities' leadership and college deans, and access to clinical training opportunities and faculty development expertise.

Through the West Michigan Interprofessional Education Initiative (WMIPEI), a conference with internationally known speakers has been held for the past three years. Active interprofessional education working groups that focus on curricular design, cross-professional competency, research, simulation and clinical practice are coordinating Grand Rapids initiatives for health professionals and faculty. Interprofessional safety and professional development initiatives are also underway with our hospital systems to coordinate interprofessional education with interprofessional patient care.

The ingredients for successful interprofessional education programs and practice are in place but we still have a lot of work to do. Let's seize the opportunity and continue to be part of the solution!

FEATURE

KENT COUNTY HEALTH DEPARTMENT

An Updated Look at Sexually Transmitted Infections in Kent County

by: Mark Hall, MD, MPH
KCHD Medical Director

A few years ago, I wrote an article for the *KCMS Bulletin* in response to the Centers for Disease Control and Prevention's 2006 report on sexually transmitted infections (STI) that focused on the increasing disease burden of chlamydia. I recently perused the 2009 version of this report, which highlighted the following trends:

- The national gonorrhea rate is the lowest ever recorded
- Continuing increases in chlamydia diagnoses likely reflect expanded screening efforts, and not necessarily a true increase in disease burden
- CDC surveillance data show much higher rates of reported STIs among some racial or ethnic minority groups than among whites.
- Less than half of people who should be screened receive recommended STI screening services.

Based upon these national trends, I figured it was time to provide an update on data from our local disease surveillance system to show how Kent County compares to what's happening around the nation. Despite a slight decrease in reported cases of chlamydia in 2009, rates of chlamydia continue to be about 3 times greater than rates of gonorrhea (Figure 1). Meanwhile, gonorrhea rates continue to decline, and rates are at their lowest level during the period for which rates are available (since 1992).

Individuals between the ages of 15 and 24 continue to be infected at a high rate. Figure 2 indicates that the decline in overall gonorrhea rates has been driven primarily by a decline in infection among individuals 15-19. A corresponding decline in chlamydia infections among 15-19 year olds has been counteracted by an increase in infections among individuals 20-24 years old. It is important to note that Kent County's surveillance system counts each STI diagnosis as a separate case if diagnoses are made more than three weeks apart. In many cases, multiple reports exist for an individual and the shift in age groups may partially be the result of individuals with repeat infections advancing to the higher age group.

Figure 1: Overall rate of reported chlamydia and gonorrhea cases, Kent County 2007–2010. *Source: Michigan Disease Surveillance System*

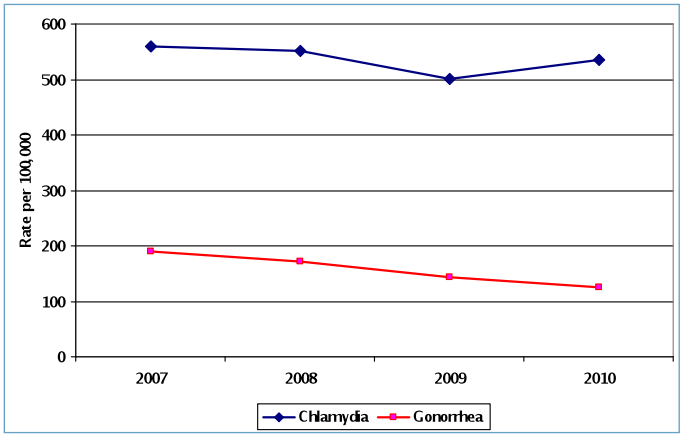
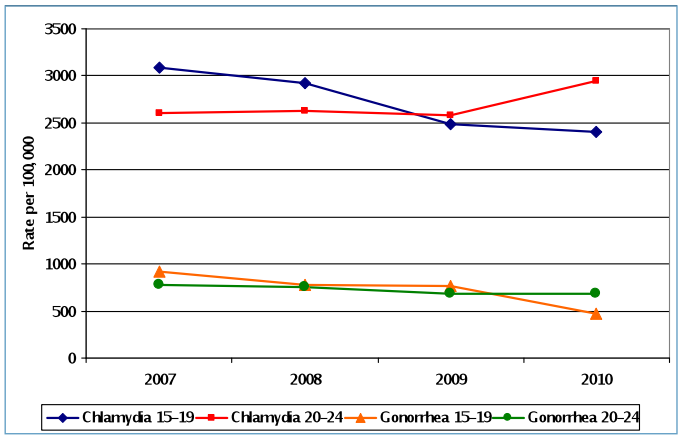


Figure 2: Sexually transmitted infection rates by age group, Kent County 2007–2010. *Source: Michigan Disease Surveillance System*



Unfortunately, one of the limitations of our local surveillance system is the fact that a number of reported cases do not include race data. On average, 1375 cases of chlamydia and 450 cases of gonorrhea each year are missing this information. Despite this, the surveillance system does provide evidence of a disproportionate burden among Kent County African Americans. In 2010, the rate of reported chlamydia infection in Kent County African Americans was 1,728 per 100,000 compared to 150 per 100,000 in Caucasians. This disparity was also evident among gonorrhea cases (480 per 100,000 among African Americans compared to 18 per 100,000 among Caucasians).

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Notifiable Disease Report

Kent County Health Department
700 Fuller N.E.
Grand Rapids, Michigan 49503
www.accesskent.com/health

Communicable Disease Section
Phone (616) 632-7228
Fax (616) 632-7085

April, 2011

Notifiable diseases reported for Kent County residents through end of month listed above.

DISEASE	NUMBER REPORTED		MEDIAN CUMULATIVE
	This Month	Cumulative 2011	Through April 2006-2010
AIDS (Cumulative Total - 872)	2	10	10
AMEBIASIS	1	2	1
CAMPYLOBACTER	2	9	12
CHICKEN POX[a]	1	5	87
CHLAMYDIA	269	1212	1081
CRYPTOSPORIDIOSIS	0	5	4
Shiga Toxin Producing E. Coli[b]	1	4	2
GIARDIASIS	11	28	23
GONORRHEA	75	266	297
H. INFLUENZAE DISEASE, INV	0	1	1
HEPATITIS A	1	2	1
HEPATITIS B (Acute)	0	0	1
HEPATITIS C (Acute)	0	0	0
HEPATITIS C (Chronic/Unknown)	20	71	103
INFLUENZA-LIKE ILLNESS[c]	4076	28858	26089
LEGIONELLOSIS	0	0	1
LYME DISEASE	0	0	1
MENINGITIS, ASEPTIC	1	3	7
MENINGITIS, BACTERIAL, OTHER[d]	0	0	2
MENINGOCOCCAL DISEASE, INV	0	1	1
MUMPS	0	0	0
PERTUSSIS	0	3	3
SALMONELLOSIS	1	9	11
SHIGELLOSIS	0	1	2
STREP, GRP A, INV	2	11	8
STREP PNEUMO, INV	5	13	27
SYPHILIS (Primary & Secondary)	1	4	3
TUBERCULOSIS	2	8	6
WEST NILE VIRUS	0	0	0

NOTIFIABLE DISEASES OF LOW FREQUENCY

DISEASE	NUMBER REPORTED Cumulative 2011	DISEASE	NUMBER REPORTED Cumulative 2011
Malaria	2		

a. Chickenpox cases are reported primarily from schools. Confirmed and probable cases are included.
b. In November 2010, cases of *E. coli* O157:H7 were combined into the category "Shiga-toxin producing *E. coli* (STEC)"
c. Includes "Influenza-Like Illness (ILI)" and lab-confirmed influenza. ILI cases have flu-like symtpoms and are reported primarily by schools.
d. "Meningitis, Bacterial, Other" includes meningitis and bacteremia caused by bacteria OTHER THAN *H. influenzae, N. meningitidis, or S. pneumoniae*.

Except for Chickenpox & Influenza-Like Illness, only confirmed cases (as defined by National Surveillance Case Definitions: www.cdc.gov/epo/dphsi/casedef/case_definitions.htm) are included.
Reports are considered provisional and subject to updating when more specific information becomes available.

FEATURE

FROM THE DEAN'S DESK

Marsha D. Rappley, MD
Dean, College of Human Medicine,
Michigan State University

As we expand our research portfolio and take advantage of the support of the Grand Rapids physician community, we are establishing divisions and, over time, departments in specialties not previously available to students and faculty.

Our first divisions established in Grand Rapids included Translational Science and Molecular Medicine, Emergency Medicine, Anesthesiology, and Radiology and Biomedical Imaging. We are now adding three new divisions in the MSU College of Human Medicine: Clinical Neuroscience, Psychiatry and Behavioral Medicine, and Dermatology.

Brien Smith, M.D., has been appointed director of the new Division of Clinical Neuroscience. Dr. Smith, chief of the Department of Neurology for the Spectrum Health Medical Group, was previously at Henry Ford Health Systems, where he was medical director of the Comprehensive Epilepsy Program and program director for the Clinical Neurophysiology residency program. Dr. Smith's research is in the area of magnetoencephalopgraphy and chronic intracranial electrical stimulation for refractory epilepsy.

The Division of Psychiatry and Behavioral Medicine in Grand Rapids is led by Eric Achtyes, M.D., as division director. Dr. Achtyes is an attending psychiatrist at Pine Rest Christian Mental Health Services. He brings his own research and that of his colleagues at Massachusetts General Hospital to diverse populations in Grand Rapids that are not often studied in psychopharmacology.

This Division will also have the support of two associate directors. William Sanders, D.O., director of the psychiatry clerkship in Grand Rapids, will serve as the Division's associate director for undergraduate medical education. William VanEerden, M.D., senior staff psychiatrist at Pine Rest, will serve as the Division's associate director for graduate medical education. Both Drs. Sanders and VanEerden bring a long history of involvement in both undergraduate and graduate medical education.

Our new Division of Dermatology is directed by Brian Nickoloff, M.D., a dermatopathologist who joins us from Loyola University Medical Center where he has been director of the Oncology Institute and deputy director of the Cardinal Bernardin Cancer Center. Dr. Nickoloff brings his renowned research in melanoma and was jointly hired in cooperation with Van Andel Research Institute.

KENT COUNTY HEALTH DEPARTMENT

CONTINUED FROM PAGE 20

Similar to national trends, Kent County females have a higher rate of reported STIs than males. For 2010, there was a larger disparity among cases of chlamydia (727 per 100,000 in females vs. 338 per 100,000 in men) than gonorrhea (140 per 100,000 in females vs. 109 per 100,000 in males). It is likely that much of this disparity is due to the fact that sexually active females receive more consistent medical care than males and thus have a higher probability of being diagnosed.

Although it is nice to see continued declines in the rate of gonorrhea in Kent County, we hope that this is due to a true decrease in disease burden rather than a lack of screening in high risk populations. Efforts to increase STI screening must target those women already utilizing healthcare who are not screened, as well as encouraging women who are not accessing care to seek screening. Given these latest data, we hope that Kent County physicians will continue to be ambassadors of good health by encouraging anyone they know at risk for an STI to get tested.

MICHIGAN MEDICAL GROUP MANAGEMENT ASSOCIATION

United We Stand!

Bob Wolford, CMPE
Executive Director,
Grand Rapids Ophthalmology
Past Chair, MMGMA

Over the past year, all of us in Healthcare have been trying to get a grip on changes that will occur as a result of the Health Care and Education Reconciliation Act of 2010 passed under President Obama's leadership and other legislation such as the stimulus package passed by Congress in 2009. Most of us have been reading and hearing about Accountable Care Organizations (ACOs) and trying to determine the ways in which our organizations will be involved in various initiatives. We have also been working to assure that we have electronic health records (EHRs) or that the EHRs that we already have will meet "meaningful use" standards being imposed by Washington.

It strikes me that many of these efforts are much easier if they are not undertaken in a vacuum. In many ways, professional organizations can help at the national, state and local levels. In addition to physician organizations like the Kent County Medical Society (KCMS), doctors should make sure that their managers and administrators are active in organizations which have been developed to educate and support them as well. In Michigan, the Michigan Medical Group Management Association (MMGMA) has established itself as one of the leading state organizations in the country, lobbying for physician friendly legislation side-by-side with physician organizations and educating managers with quality programs that rival many national meetings. Together, these organizations form a solid support system for medical groups and provide for appropriate dialogue regarding all of the issues that will be heading our way.

As an example of this support, the MMGMA's recent spring meeting in Mount Pleasant featured speakers on the very topics noted earlier. Specifically, several speakers addressed work being undertaken right here in West Michigan to prepare for an ACO environment. Drs. Kent Bottles and David Blair, as well as Roberta Jellink and Molly McCarthy offered various perspectives on the issue, including an overview of the challenges for hospitals, physicians and health plans in an ACO environment.

Doctors and managers should remember, however, that synergy can take place in other ways beyond these types of professional organizations. Specialty practices may want to investigate ways to work with primary care practices to deliver services to their mutual patients in a way that is more convenient for everyone. Even large practices may be able to save money and thus be more efficient in their delivery of care by joint venturing with other practices which have a similar culture and philosophy. By thinking outside the box, practices may joint venture and find that vendors can be persuaded to sweeten their pricing since the stakes have become more significant.

By taking a broader (more community oriented) view of these significant issues that face them, health care providers, regardless of the size of their organizations, might just find that the complexity wanes and that the future seems more manageable than it would have been had they faced the future alone.

MEETINGS OF INTEREST

JUNE 16–19, 2011

NMOA & MOA Annual Summer Conference 8:00am–5:00pm
Mission Point Resort, Mackinac Island
Approximately 22 hours of Category 1-A CME credits anticipated.
For more information, contact:
Kristy Kenyon • 800-657-1556 • kkenyohn@mi-osteopathic.org
Registration is required.

AUGUST 4–7, 2011

MAOFP Summer Family Medicine Update 8:00am–5:00pm
Grand Traverse Resort, Traverse City, MI
20–22 hours of Category 1-A CME credits anticipated.
For more information, contact:
Sara Carson • 800-657-1556 • scarson@mi-osteopathic.org
Registration is required.

AUGUST 13, 2011

KCOA CME Update 7:00am–12:30pm
Grand Rapids Hilton Airport
4 hours of Category 1-A CME credits anticipated.
For more information, contact:
KCOA Office • 616-458-4157 • kcmsoffice.org
Registration is required.

DOCTORS IN THE NEWS

Craig Bethune, DO was honored for 30 years of service by the Michigan Osteopathic Association. He is a MOA past president, chairs MOA's Council on Government Affairs and is in his third consecutive term as MOA House of Delegates Speaker.

Mentioned in *THE GRAND RAPIDS PRESS* Health Section:

Gary Marsiglia, DO was mentioned concerning his work as Medical Director with Care Resources. This is a one-stop shopping medical home that provides care for the elderly through a program known as PACE, Program of All-inclusive Care for the Elderly.

Megan Looby, DO and **Steve Lown, DO** were mentioned in an article on the celebration of Doctors' Day. They were recognized by patients in appreciation for the healthcare delivered.

John Serini, DO discussed the importance of colorectal cancer screening. He discussed what who should be screened, what is involved and prevention.

CHECK OUT
OUR WEBSITE
KCOA.us

PRESIDENT'S MESSAGE

Ann M. Auburn, DO
KCOA President

Medicine is a profession that is constantly changing. Like much of the world around us, we must deal with the changes in politics, the economy and society as a whole. This is not new to medicine. Even in the early 1900's there was change in medicine that was difficult for physicians. From an article written in the California State Journal of Medicine in 1916, the following quote: "Medicine," using the word in its broadest sense, as a profession, calling or occupation, is changing very rapidly; more rapidly than most of us believe or understand, and so rapidly that many physicians resent the results of the changes without realizing their cause or their import." (Ref: Cal State J Med. 1916 October; 14(10): 388.) The article goes on to discuss the advantages of "State Medicine" as a method of medical practice to keep the wage-earner healthy because "Economically, the sick wage-earner is a burden on the whole community." I'm not sure "State Medicine" was the best solution, but I do agree that keeping people healthy is good for our economy. But, isn't it interesting that even back then, physicians were struggling with the best ways to cope with changes as we conduct our daily tasks of caring for patients? So much of how we deal with these changes has to do with our viewpoint. Following with this concept, at least one of the questions we must ask ourselves is, what attitudes and viewpoints can we decide to take to confront and improve the current state of medicine while we deal with the many changes in our economic recession, the health care system, insurance and our patients? I found the following quotes helpful in taking a new look at how anyone can make contributions. I share these with you now, so that you can enjoy them and reflect on how you might use these suggestions to conduct yourself in any dealings you may have with politicians, administrators, colleagues and opinion leaders, as well as in the care of your patients.

"A man is but the product of his thoughts. What he thinks, he becomes."
—Mohandas K. Gandhi

"You cannot hope to build a better world without improving the individuals. To that end each of us must work for his own improvement, and at the same time share a general responsibility for all humanity, our particular duty being to aid those to whom we think we can be most useful."
—Marie Curie

"You must be the change you wish to see in the world."
—Mohandas K. Gandhi

"Have patience with all things, but chiefly have patience with yourself. Do not lose courage in considering your own imperfections but instantly set about remedying them – every day begin the task anew."
—Saint Francis de Sales

"Observe always that everything is the result of change, and get used to thinking that there is nothing Nature loves so well as to change existing forms and make new ones like them."
—Marcus Aurelius
Roman Emperor from 161 to 180 (He was the last of the "Five Good Emperors", and is also considered one of the most important Stoic philosophers.)

These quotes may inspire you to decide what you can do to contribute to the future of medicine. Some of us may do it in the small ways we deal with individuals every day or in a larger way by dealing with groups or organizations that we come across in our professional work. As always, if you are inspired to share your thoughts or opinions as to how the KCOA can be a resource for you and our community, you can send your suggestions to me or any of the Kent County Osteopathic Association Board members. The newly formed Board that was voted into place at our recent membership meeting on May 3, 2011 is:

Ann M. Auburn, DO	*President*
Adam T. Wolfe, DO	*President-Elect*
Laura A. Tinning, DO	*Secretary*
Brad A. Irving, DO	*Treasurer*
Dorothy A. "Robin" Pedtke, DO	*Director*
Karlin E. Sevensma, DO	*Director*

You can send your suggestions to me or any of the Kent County Osteopathic Association Board members as well as the Executive Director, Patricia Dalton at (616) 458-4157 or e-mail (Patricia@kcms.org).

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