THE Bulletin

March 2015 Volume 96, Number 13

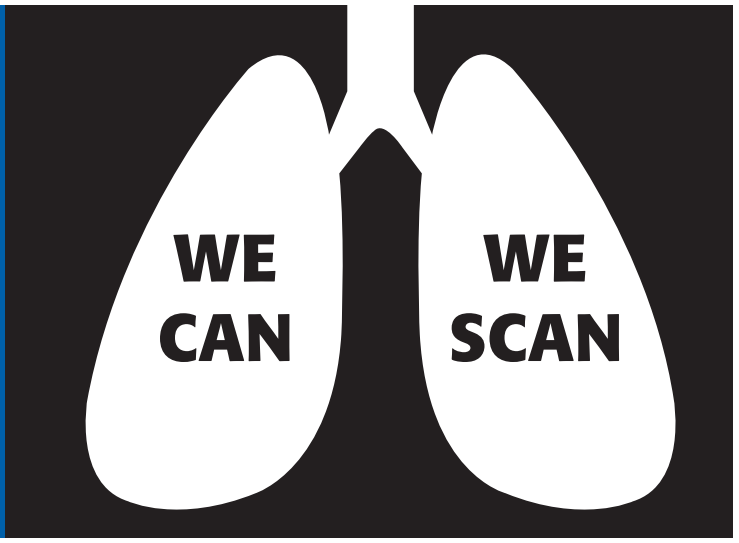
PGIP Meeting Wrap-Up

Contact information for Elected Officials

Who Pays Estate Taxes?

GENESEE COUNTY MEDICAL SOCIETY
Organized Medicine's Leading Edge

CAN YOU SEE THEIR LUNGS?



TELL YOUR AT-RISK PATIENTS ABOUT OUR

CT LUNG CANCER SCREENING

UTILIZING A SPECIFIED LOW-DOSE (LDCT) PROTOCOL

Early detection of lung cancer leads to easier treatment, reducing deaths by 20% more than chest x-rays. Most insurance carriers (including Medicare) provide coverage, subject to eligibility. RMI also offers a $149 cash pay option.

SCREENING ELIGIBILITY:

- 55-77 years of age
- Current smoker or quit smoking within the last 15 years
- Have smoked at least 30 pack years
  (1 pack-year = smoking one pack (20 cigarettes) per day for 1 year
- No history or symptoms of lung cancer

- LDCT reduces lung cancer mortality rate 20% compared to chest x-ray
- RMI is ACR accredited for lung screening
- We manage patient follow-ups making your job easier
- CTLS program headed by Dr. Ehab Youssef, thoracic radiology fellowship trained at University of Michigan

RMI
REGIONAL MEDICAL IMAGING
Clearly. Better. Choice.
rmipc.net ▪ (810) 732-1919

2/15

CT screenings are offered at three of our six locations: Lennon Rd, Flint ▪ Fenton ▪ Grand Blanc

THE BULLETIN is published monthly by
The Genesee County Medical Society.

March 2015 Volume 96, Number 13

THE Bulletin

Read by 96% of GCMS members.

FEATURE ARTICLES

REGULARS

Cover photo by by Dr. Cyrus Farrehi

Our Vision
That the Genesee County Medical Society maintain its position as the premier medical society by advocating on behalf of its physician members and patients.

Our Mission
The mission of the Genesee County Medical Society is leadership, advocacy, education, and service on behalf of its members and their patients.

PLEASE NOTE
The GCMS Nominating Committee seeks input from members for nominations for the GCMS Presidential Citation for Lifetime Community Service. The Committee would like to be made aware of candidates for consideration.

THE BULLETIN
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By subscription $60 per year. Member subscription included with Society dues. Contributions to THE *BULLETIN* are always welcome. Forward news extracts or material of interest to the staff before the 5th of the month. All statements or comments in *THE BULLETIN* are the statements or opinions of the writers and are not necessarily the opinion of the Genesee County Medical Society.

GREETINGS FROM BUCKEYE NATION

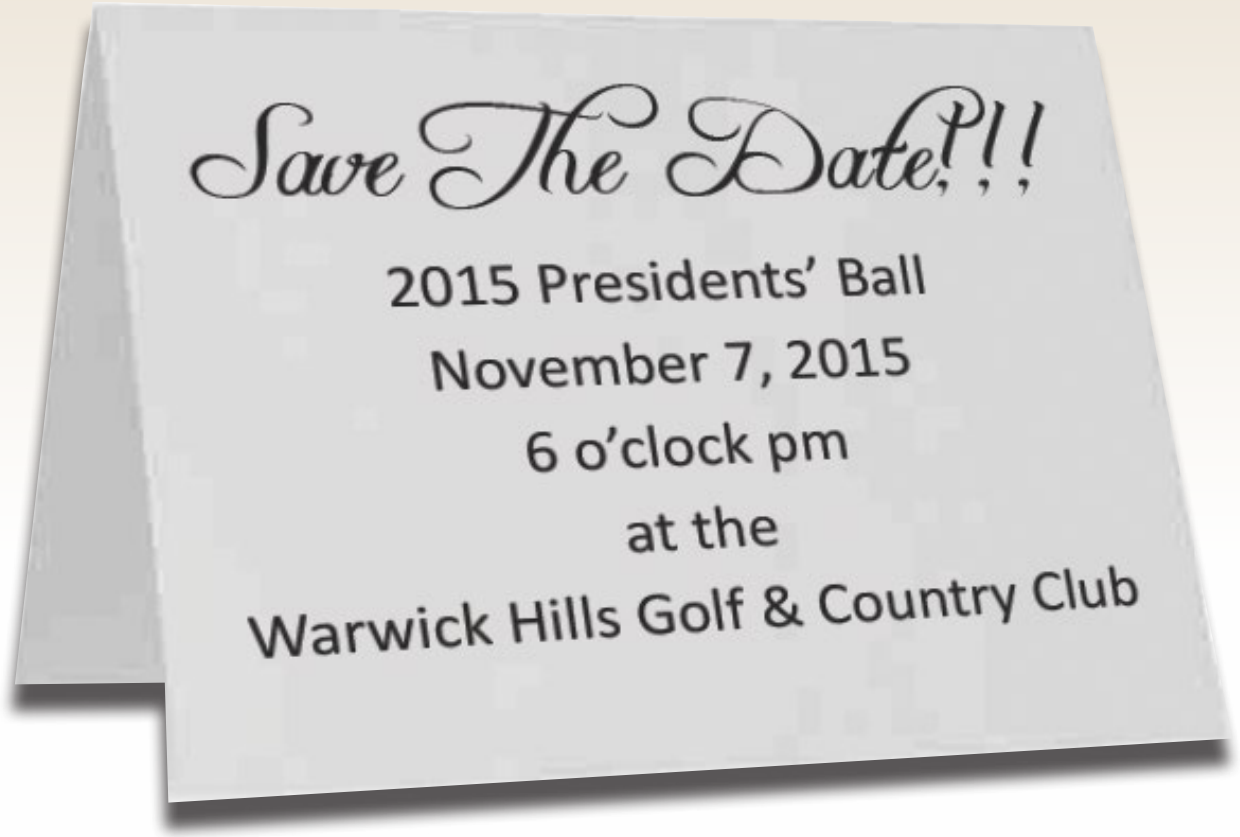
Deborah Duncan, MD

Someone asked me last week if our office was still seeing patients who refuse their vaccines. The answer is yes, but we are also still debating the subject. As a diplomat of the American Board of Preventative Medicine, I believe that sometimes public health issues trump personal desires. I believe that TB patients who cannot reliably take their medications, can be forced to do so, and even detained until they are declared non-infective. We have certainly used house quarantine during times of infectious disease outbreak. Smallpox would not have been eradicated if parents had had to give permission for their child to be vaccinated. I see this as the medical equivalent of Eminent Domain.

Because getting a child vaccinated effects not only that child, but the whole community, I believe vaccination should be compulsory.

So why do we still see these patients? It is because we use our influence to teach parents and sometimes we can convince them. For those patients, we believe this is better and more effective for public welfare. It does still leave us fearing that infants in our office could inadvertently be exposed. So, we are still debating.

What has also been debated is, what to do about adult patients who refuse their Tdap (Tetanus, Diphtheria, Pertussis). Certainly tetanus is not a threat to people near you, but diphtheria and whooping cough are. Whooping cough has made a resurgence. Now we run the risk of an under-vaccinated adult spreading whooping cough or diphtheria in our waiting room. I do find it interesting that Medicare will pay for the Prevnar 13 booster, but still will not pay for the Tdap. At $85, most of my Medicare patients refuse it. Should we turn these patients away also? Which action is right for all of our patients? It is an ongoing debate. Where do you stand?



WE WANT YOU FOR THE LEGISLATIVE LIAISON COMMITTEE!

Young physicians - are you looking for interchange with your legislators?

Seasoned physicians - would you like to help bring GCMS and MSMS positions to the forefront?

Become involved in the GCMS Legislative Liaison Committee!

Be a part of an elite group of communicators who meet with our elected officials.

You are invited to engage in conversation with your legislators on the first Monday of each month at 8:00am in the Rapport Conference Room at the GCMS office.

You may contact Pete Levine at plevine@gcms.org or call ***810.733.9925***, if you would like to participate.

This is a valuable opportunity; don't let it go to waste!

EDITORIALLY SPEAKING

DOCTOR, ARE YOU PREPARING FOR THE END?

From poverty to wealth is a hard journey, but the way back is easy.

Japanese proverb

Daniel Ryan, MD

A recent discussion with a friend and colleague turned to the topic of financing an eventual retirement from the practice of medicine. He recently moved into a large, beautiful, owner-occupied office with additional space for hoped-for tenants, opened a satellite office several miles away, did extensive remodeling of his home, and is trying to save for the education of his three children. Add to the above the cost of oppressive medical school loans and the day-to-day life maintenance expenses. Trying to keep all of his financial plates spinning leaves little time or money to devote toward retirement planning, but it should not be so.

While physicians generally have incomes much higher than the average person, a wise old father once said, "It's not what you make, but what you keep that matters". Most physicians are small business owners and, as such, must provide for themselves when it comes to retirement financing. No generous government or corporate sugar daddy is going to pay your bills after you stop practicing. The goal should be to accumulate sufficient assets to maintain your lifestyle. "In general, a person will need seven to eight times his or her annual compensation in savings to have a shot at this goal," says Greg Kasten, M.D., who began a second career as a Certified Financial Planner catering to medical groups. Statistically, doctors and their employees will not reach their destination.

Americans are generally poor savers and 80% of us do not save enough to continue our current lifestyle after retirement. The savings rate in the U.S. was actually a negative figure last year. The usual culprits are inertia and procrastination and physicians are not immune. If your retirement fantasies include exotic travel, expensive hobbies, or a second home in a warm climate, you will likely require even more income after retirement. One financial planner reported that many of his physician clients spent in excess of 150% of their pre-retirement income when fully retired.

To avoid living in a cardboard box and rummaging for food in dumpsters after you hang up your stethoscope, professional retirement planning consultants have some recommendations. Educate yourself about financial matters and retirement plan options and products, even if you have a financial planner that handles your assets. Sometimes their goals are not the same as yours. Watch for hidden fees and unwarranted expenses and review your retirement portfolio regularly. Stay diversified and avoid get-rich-quick tips and schemes. Think of retirement planning as a lifelong process, start early and increase your contributions to your retirement fund each year. Plan on accruing the financial resources to spend at least one-third of your life as a retiree. Above all, enjoy and spend some, but not all, of your hard earned money today.

My friend joked that his retirement plan consisted of working and worrying himself to an early demise so that his wife, her new husband, and his kids can enjoy the fruits of his labors. Stay away from his retirement planner.

MSMS New Lawmaker Reception

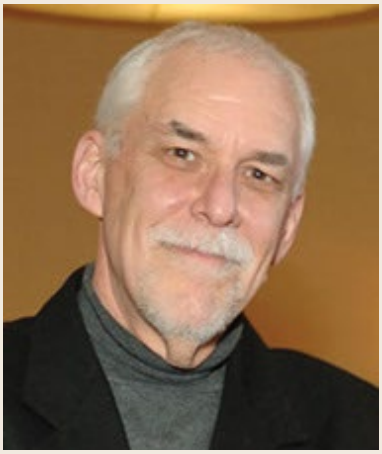
In Mid-February, the Michigan State Medical Society hosted its New Lawmaker's Reception bringing membership and staff into direct contact with new legislators. The reception was a wonderful opportunity to educate legislators about the issues physicians face in this challenging environment.

MSMS and GCMS members spoke to the legislators about scope of practice, auto no-fault, Graduate Medical Education funding, and maintenance of certification reform, among other issues.

GCMS representatives present included: Dr. John Waters, Dr. and Mrs. Michael Danic, Dr. James Forshee, and Pete Levine.

Legislative Attendees included: Senator Tonya Schuitmaker; Senator Margaret O'Brien; Senator Peter MacGregor; Senator Curtis Hertel, Jr.; Representative Mike Callton; Representative Edward Canfield, DO; Representative Jim Tedder; Representative Bill LaVoy; Representative Tom Cochran; Representative Marcia Hovey-Wright; and former Senator Roger Kahn, MD.

THOUGHTS ON THE PGIP DINNER BUSINESS MEETING AND PEER REVIEW



Peter Levine, MPH

In early February, GCMS held a General Membership Meeting which focused on a presentation by Dr. Tom Simmer, on the Blue Cross Blue Shield of Michigan Physician Group Incentive Program. As usual, Dr. Simmer's presentation was highly stimulating. He is a skilled communicator and a fine thinker. Those who missed the meeting, are encouraged to attend future meetings, which we will have on similar issues. The energy in the room was quite strong. Attendance was split, approximately 50% primary care and 50% specialty physicians. There were also several practice managers and staff in attendance. One of the most interesting things about that evening, was that after the meeting was concluded, the room did not clear out until 9:30 p.m. People were talking, heavily engaged in discussion. It was the first time, in quite a while, that so many new faces were in attendance at a meeting of this sort. There were people talking to one another, who had not met previously, who were looking for ways to benefit from new professional relationships and new, potential affiliations.

This has been an interesting period of time for staff, we have been working hard to dispose of the paper clutter, in much the same way as many of our members' practices have been. Recently, we engaged in the process of purging the Peer Review files, going back scores of years. My purpose in bringing this up, is not to mention any particular cases, although there are many interesting files that have gone through the shredder. The reason for mentioning this, is to let the members know, that we have this Peer Review process in place for the purpose of mediation, and also discipline. While this may seem like a pain in the neck, and possibly threatening, it is actually, a service to our members. Who knows how many malpractice cases have been avoided, because a group of physicians gathered together, and were able to dissect facts and explain to a patient or patients' family, or even to a peer, what actually went on. There have been plenty of occasions where complex issues were handled between peers, for the purpose of improving quality, or to handle ethical issues.

The complaints do not come in as often as they used to, but when they do, a substantial number of members still volunteer to help with this process. This process is one that the community at large, greatly appreciates. It also results in substantial improvement in the image of the profession in the community at large. If interested, please do not hesitate to let an officer, or myself, know. If a complaint comes in, relating to you as a member, please be responsive to the Mediation and/or Peer Review Committee and understand they are doing their best to assist you and the patient.

SINGLE DRUG FORMULARY ANNOUNCED FOR MEDICAID MANAGED CARE PLANS

The Michigan Department of Community Health (MDCH) recently announced changes in the upcoming request for proposal (RFP) for the Medicaid Managed Care Health Plans.

Starting with the new contracts, effective January 1, 2016, pharmacy services that have been covered by the Medicaid Health Plans will be carved out. Currently, each Medicaid Health Plan has their own formulary for covering drugs. All pharmaceutical services for Michigan Medicaid beneficiaries will no longer be the responsibility of the Medicaid Health Plans and will be through a single contracted pharmacy entity. This change will result in cost savings through increased pharmaceutical rebates and administrative efficiencies at the state level; and, will also result in significantly streamlined administration for providers.

The health plans have organized around a campaign to question the need for a single drug formulary. The Michigan State Medical Society (MSMS) needs your help. In order for MSMS to act on your behalf, we are in need of practices that will share their experiences with costs, time and administrative hassle it takes to have multiple formularies for your Medicaid patients.

Multiple formularies have been a challenge for physicians, hospitals and patients. The complexity of multiple coverage arrangements takes time. It is yet another administrative hassle that practices absorb while accepting 60 cents on the dollar for participating in Medicaid. If Medicaid cannot pay the costs of caring for a patient, why can't it eliminate as many hassles as possible for the provider?

As an MSMS member, we are advocating on your behalf. Please watch your inbox for additional engagement on this issue.

For more information or to share your story, please contact Rebecca Blake at 517-336-5729 or rblake@msms.org.

Do you recognize this DOCTOR?

Look for the Answer inside!

Wash Hands Often and Appropriately

Whei Ying Lim, MD
Pediatric Resident, Hurley Medical Center

Hand washing is like a "do-it-yourself" vaccine. It is one of the best things we can do to keep ourselves from getting sick, and avoid spreading germs to others. Germs can get onto hands if people touch any contaminated object. Touching a contaminated handrail after someone may have coughed or sneezed onto is a common example. Germs from feces like Salmonella, E.coli, and Adenovirus can get onto hands and spread quickly if careful washing is not done after using the toilet or changing a diaper. Hand washing with soap removes germs and helps to prevent infections. Hand washing education in the community reduces the number of people who get sick with diarrhea by 31%, and reduces diarrheal illness in people with weakened immune systems by 58%. It also reduces respiratory illnesses, like colds, in the general population by 21%.

So when should we wash our hands? We should wash our hands before, during and after preparing food, before eating food, before and after caring for someone who is sick, using the toilet, changing diapers, blowing our nose, coughing or sneezing, touching an animal, and touching garbage. How should we wash our hands in order to kill the germs and prevent transmission of germs? There are five simple and effective steps: wet, lather, scrub, rinse and dry. First, wet your hands with clean running water; lather your hands by rubbing them together with the soap. Be sure to lather the back of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds or you can hum the "happy birthday" song from beginning to end twice. Then rinse your hands under clean, running water and dry your hands using a clean towel or air dry them. If water and soap are unavailable, use an alcohol-based hand sanitizer that contains at least 60% alcohol. For hand sanitizer, we can apply the product to the palm of one hand and rub the product over all surfaces of your hands and fingers until your hands are dry. However, hand sanitizers are not effective when hands are visibly dirty or greasy.

It is important for parents to inculcate hand washing habits in children from an early age. It is simple enough for even very young children to understand. Hand washing with soap could protect about 1 out of every 3 young children from diarrhea and almost 1 out of 6 young children from respiratory infections like pneumonia. Hand washing reduces the chance of illness and chronic inflammation in children, leading to better nutrition intake, more energy available for growth and development, and better attendance at school. Hand washing also increases productivity indirectly by reducing illnesses. Less time will be spent at the doctor's office and more time will be spent at work or school. In health care settings, hand hygiene is one of the important ways to prevent the spread of infections. Patients and their loved ones can play a role in helping to prevent infections by practicing hand hygiene themselves as well as reminding their healthcare providers to perform hand hygiene.

Despite widespread knowledge of the importance of hand washing, there is still room for improvement. According to one recent study, only 31% of men and 65% of women washed their hands after using public restrooms. In short, clean hands save lives. Have you washed your hands with soap today?

LEGAL ADVISOR

WHO PAYS ESTATE TAXES?

By Timothy H. Knecht, Esq., Cline, Cline & Griffin, P.C.

The thought of paying estate taxes is revolting to many people. Estate tax laws are complex and no one likes the idea of giving the government something, just because of the death of a person.

The good news is that only a few people ever have to pay any estate tax. In 2015, an individual can die with $5.53 million in assets and still pay no estate tax. This means a couple can die with almost $11 million in assets and not have to pay any estate tax. Under current law, the $5.43 million figure is indexed for inflation and will rise annually.

What counts towards this $5.43 million dollar number? Everything. Your home, any other real estate you own, the value of your life insurance, even though you will never see that during your lifetime, the value of any annuities, the value of your investments, money in the bank, the value of your professional practice, the value of your retirement accounts and even personal property. For example, if you have a $1 million life insurance policy payable to your spouse upon your death, that $1 million is counted in your estate when you die. If your home is owned jointly, the value of the home is counted in the estate of the last person to die. Retirement accounts are counted in the estate of the person to whom the retirement account belongs even though, upon the death of that person, the value in the retirement account will usually be passed on to a surviving spouse or others. The same is true with annuities. If you own an investment account in your own name, it is counted in your estate. If it is a joint account, it is counted in the estate of the last person to die. Complicated? Yes. Unmanageable? No. If you are fortunate enough to have over $5.43 million in assets, all that is required is some planning to help divide the ownership of assets between spouses, if applicable. If you have $5.43 million in assets or more and do not have a spouse, there are a variety of other ways to protect your assets from estate taxes as well, but it does take planning.

Setting up a Trust, or several Trusts during your lifetime and, very importantly, funding your Trust or those Trusts appropriately, that is making the Trust or the Trusts either the owner or the beneficiary of virtually all of your assets, goes a long way towards protecting you against estate taxes and establishes a plan to take care of your loved ones after you are gone. That could be even more important than avoiding estate taxes.

Again, the good news is that not a lot of people have to pay estate taxes under today's rules because the amount exempt from estate taxes, $5.43 million in 2015, is a relatively large number and will keep rising into the future. If you are lucky enough to face a potential burden of estate taxes, planning helps. The price for not making a plan is 40% of everything over $5.43 million, a pretty stiff penalty Please feel free to contact the undersigned for a more in-depth discussion of this complex issue.

RESPECTUFLLY SUBMITTED
AND PREPARED BY:

Timothy H. Knecht
Cline, Cline & Griffin, P. C.
503 S. Saginaw Street
Suite 1000
Flint, MI 48502
(810) 232-3141

YOUR $$$ AT WORK

- GCMS hosted General Membership Meeting on the Blue Cross Blue Shield of Michigan, Physicians Group Incentive Program with Dr. Tom Simmer, MD, Senior Vice President, Chief Medical Officer, BCBSM
- GCMS and MSMS met with new Genesee County State Senator, Ken Horn
- GCMS worked with the City of Flint to develop a statement for physicians on water related health issues
- GCMS worked with two physicians regarding third party payer certification issues
- GCMS held a Practice Manager Session on "What's Coming Down the Pike at Practices", and planned a session on MIOSHA and OSHA
- GCMS pursued avenues for arranging transportation for disadvantaged patients
- GCMS is working closely with the Michigan State Medical Society on establishing relationships with new legislators representing this community

If you or someone you know would like to advertise in The Bulletin please contact Sherry Smith at ssmith@gcms.org or call (810) 733-9923.

JANUARY PRACTICE MANAGERS MEETING

The January meeting of GCMS Practice Managers featured a presentation by Joshua Richmond, MSMS Director of Membership, and MD-PAC. The topic was "What's Coming Down the Pike at Practices."

Mr. Richmond reported that the Medicare Sustainable Growth Rate formula, which was put in place in 1997, will hopefully be patched in the near future. It is also hoped that a deferred date for implementation of ICD-10 will also go into effect. The U.S. Supreme Court will rule again on elements of the Accountable Care Act on issues relating to Federal Exchange Insurance Policies. If struck down, the ruling will impact the ability of exchanges to perform the work necessary to sell policies. Specifically, states, including Michigan, that use the federal exchange might not be able to pass federal premium subsidies to enrollees, preventing many from being able to afford the policies.

It is expected that HIPPA will result in expanded impacts on practices. Mr. Richmond noted that the fines are massive and that concentration by practices on HIPPA related issues will need to increase.

At the state level, the budget is under pressure. Options are being sought to fill revenue holes. Medicaid reimbursement and Graduate Medical Education are on the table. MSMS and GCMS are monitoring the process and working hard to avoid deleterious impacts on both issues.

Auto no-fault insurance is under significant pressure from insurance companies who are trying to change the process. MSMS and trial attorneys are on the same page on this particular issue. The insurance companies are trying to create caps on damages, a $10,000 cap on medical care, and implementation of fee schedules.

Scope of practice will continue to be a major state level issue. MSMS defeated a Bill that would allow APNs and CRNAs to practice independently of physicians. MSMS is writing a bill emphasizing team-based care with physicians at the lead.

Certificate of NeQed is a process which is under pressure in Michigan as well. MSMS feels that Certificate of Need limits competition. The Economic Alliance loves Certificate of Need to control costs so a fight is coming.

Two physicians were elected to the Michigan House of Representatives. There are 148 state lawmakers who make decisions on health care, and having two new physicians in the Legislature will be helpful. Narrow networks are a major developing issue. Health insurance companies are working on narrowing networks for exchanges. MSMS is monitoring to make sure it is not impacting plans which are not exchange based.

The issue of retroactive audits is one that MSMS is working hard on. Insurers can go back many years, retroactively, to seek repayment for physicians. MSMS is trying to establish a time limit for retroactive audits.

Save The Date!

2015 Presidents' Ball

November 7, 2015

Warwick Hills Golf & Country Club

GREATER FLINT HEALTH COALITION

RESOLUTION TO SUPPORT A REDUCTION IN SUGAR SWEETENED BEVERAGE CONSUMPTION AND INCREASED WATER CONSUMPTION AS A PRIORITY STRATEGY TO IMPROVE HEALTH IN FLINT AND GENESEE COUNTY

WHEREAS, sugar-sweetened beverages (SSBs) including soda, fruit punches, sports drinks, energy drinks, sweetened tea, and other carbonated or uncarbonated drinks that are sweetened with sugar, corn syrup, or other caloric sweeteners are the largest source of added sugar in the American diet today;

WHEREAS, Genesee County has a 36% adult obesity rate compared to 32% for the state of Michigan and 25% as the national benchmark and sugar-sweetened beverages are linked to more than 180,000 obesity-related deaths worldwide each year;

WHEREAS, a significant increase over the past 3 decades of caloric intake from Sugar-sweetened beverages includes an increased average portion size (from 13.6 ounces to 21 ounces) and an increased number of servings per day (from 1.96 to 2.39);

WHEREAS, since 1965, sugar-sweetened beverage consumption has increased significantly: Approximately a 100% increase for children (from 94 calories per day to 191 calories per day) and approximately a 250% increase for adults (from 55 calories per day to 195 calories per day);

WHEREAS, over consumption of sugar-sweetened beverages contributes to a myriad of chronic diseases and health conditions for both children and adults, including obesity, diabetes, hypertension, dental health and coronary heart disease;

WHEREAS, each additional 12-ounce soft drink consumed per day by children increases their odds of becoming obese by 60%;

WHEREAS, scientific evidence suggests that sugar sweetened beverages contribute to the epidemic of obesity in the U.S., with the effects observed to be strongest in children;

WHEREAS, the Greater Flint Health Coalition is a nonprofit Michigan collective impact organization whose mission is to improve the health status of the residents of Genesee County and to improve the quality and cost effectiveness of the health care system in Genesee County;

WHEREAS, the Greater Flint Health Coalition's strategic business plan has a focus area of Health Improvement with a goal to promote and advocate for policies and practices at multiple levels of society that engage our community's residents in healthy behaviors;

WHEREAS, the Greater Flint Health Coalition's County Health Rankings Action Plan identified an increase of healthy food access and improved nutrition and diet in workplaces, campuses, and other community settings as a strategy to be implemented to improve health behaviors in Genesee County;

WHEREAS, the Greater Flint Health Coalition seeks to support a reduction in sugar-sweetened beverage consumption and to promote the increased consumption of water, a readily accessible, calorie free and healthy alternative to SSBs as a strategy to improve the practice of healthy behaviors;

NOW, THEREFORE, IT IS HEREBY RESOLVED that the Board of Directors of the Greater Flint Health Coalition, composed of representatives and leadership from Genesee County's hospitals, physicians, healthcare providers, health insurers, business, government, educators and schools, organized labor, and community residents, strongly support a community-wide reduction in sugar-sweetened beverage consumption in Genesee County and Flint as it would: contribute to a decrease in the overall rates of overweight and obesity, encourage healthy behavior alternatives such as increased water consumption, and significantly decrease the likelihood of illness, disease, and death among residents due to the scientifically documented harmful side-effects of high consumption of sugar-sweetened beverages.

THIS RESOLUTION has been adopted by the Genesee County Medical Society effective 11/25/2014.

Peter Levine, Executive Director

HEALTH-8I SSB.Resolution.102314nb

Issues Of Serious Concern For Medical Practices!

Don't let your practice manager miss these important meetings!

March 26, 2015

Topic:
Legal Issues for the Medical Practice

Presenter:
Jonathan Hartman, Esq
Cline, Cline and Griffin

Held 4th Thursday of each month from 8am to 10am.

Genesee County Medical Society
Rapport Conference Room
4438 Oak Bridge Drive, Suite B
Flint, MI 48532

Light breakfast available
(coffee, tea, fruit cups, granola bars)

Commit to Fit! Fitness Classes

Commit to Fit! offers **FREE** fitness classes and healthy cooking demonstrations to all individuals who live or work in Flint and Genesee County. Depending on the facility, participants may be asked to complete a brief registration form prior to attending a class. See back side for details.

MARCH 2015 SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
MARCH 2015	2	3 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Healthy Cooking Demonstration** Flint Farmers' Market 12:00 p.m. **Enhance Fitness** Carriage Town Ministries 2:30 p.m.	4 **Zumba Gold (Beginner)** GAC 5:30 p.m.	5 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Basic Yoga** IHFC 6:45 p.m.	6 **Zumba! Toning®** UM-Flint Rec 5:30 p.m.	7 **Healthy Cooking Demonstration** Flint Farmers' Market 12:00 p.m.
	9	10 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Healthy Cooking Demonstration** Flint Farmers' Market 12:00 p.m. **Enhance Fitness** Carriage Town Ministries 2:30 p.m.	11 **Zumba Gold (Beginner)** GAC 5:30 p.m.	12 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Basic Yoga** IHFC 6:45 p.m.	13 **Zumba! Toning®** UM-Flint Rec 5:30 p.m.	14
	16	17 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Healthy Cooking Demonstration** Flint Farmers' Market 12:00 p.m. **Enhance Fitness** Carriage Town Ministries 2:30 p.m.	18 **Zumba Gold (Beginner)** GAC 5:30 p.m.	19 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Basic Yoga** IHFC 6:45 p.m.	20 **Zumba! Toning®** UM-Flint Rec 5:30 p.m.	21
	23	24 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Healthy Cooking Demonstration** Flint Farmers' Market 12:00 p.m. **Enhance Fitness** Carriage Town Ministries 2:30 p.m.	25 **Zumba Gold (Beginner)** GAC 5:30 p.m.	26 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Basic Yoga** IHFC 6:45 p.m.	27 **Zumba! Toning®** UM-Flint Rec 5:30 p.m.	28
	30	31 **Enhance Fitness** Flint Farmers' Market 10:00 a.m. **Healthy Cooking Demonstration** Flint Farmers' Market 12:00 p.m. **Enhance Fitness** Carriage Town Ministries 2:30 p.m.				

Class Descriptions & Locations

Basic Yoga (1 hour) - This class is a balanced flow of postures designed to build stamina, strength, and flexibility while promoting weight loss and general stress relief.

Insight Health & Fitness Center (IHFC)
Formerly Hurley Health & Fitness Center
4500 S. Saginaw St
Flint, MI 48507

Zumba Gold (1 hour) - A less intense version of the classic Zumba. This class offers fun music to keep the excitement high while keeping the impact low.

Genesys Athletic Club (GAC)
801 Health Park Blvd
Grand Blanc, MI 48439
(810) 606-7300

Zumba! Toning® (1 hour) – Combines targeted exercises and high-energy cardio work with Latin-infused Zumba!® moves to create a calorie-torching, strength-training, dance fitness-party.

University of Michigan-Flint Recreation Center (UM-Flint Rec)
401 Mill Street (for mapping)
303 E. Kearsley
Flint, MI 48502
(810) 762-3441

Healthy Cooking Demonstration (1 hour) – Learn how to cook a simple, healthy dish by a vendor at the Market and try a sample after!

Flint Farmers' Market
300 E. First St
Flint, MI 48502
(810) 232-1399

Enhance Fitness (1 hour) – A fun, energizing class geared toward improving overall functioning and well-being. Improve your cardiovascular fitness, strength, flexibility and balance!

Flint Farmers' Market
300 E. First St
Flint, MI 48502
(810) 232-0522

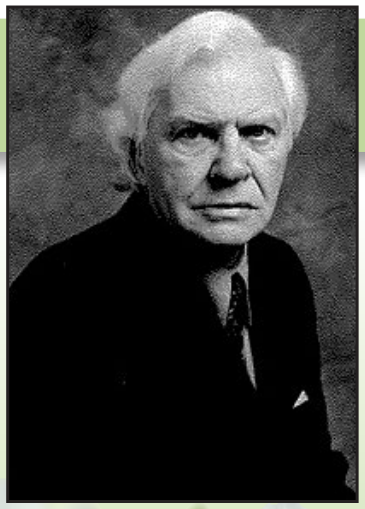
Carriage Town Ministries
605 Garland Avenue
Flint, MI 48503
(810) 233-8787

Questions?
Email
commit2fit@flint.org

For updated monthly calendars of the *Commit to Fit!* Fitness Classes visit:

commit2fit.com

MIC-6C3 FEBRUARY.Fitness.Class.Calendar.12015.na



John Leslie Brady, MD

John L. Brady, MD, passed away on December 4, 2014.
Dr. Brady was born in London, England. After returning from six years in the Royal Navy he went to the University Of London School Of Medicine, Charring Cross Medical College. He moved to Canada with his wife C. Margaret Brady and four of his future five children. He performed internships at Charring Cross Hospital and at University of Alberta. In 1962 he brought his family to the United States, where he completed a cardiology residency at Henry Ford Hospital in Detroit. He served as an attending at Henry Ford Hospital as well. He then opened the first cardiac catheterization laboratory, cardiology unit and cardiac surgery unit in Flint, Michigan at St Joseph's Hospital. He was devoted to his family, friends, work and patients. Hobbies included history, poetry, music, drama, sailing, skiing, climbing, tennis, and racing cars.
A Memorial service will be announced at a later date.

Maurice L. Robitaille, MD

1933 - 2015

Maurice L. Robitaille, MD, age 81, passed away on January 18, 2015.
Dr. Robitaille was born in Lewiston, Maine in 1933. He attended Assumption College in Worcester, Massachusetts. He performed military service from 1953 to 1955. He attended medical school at Ottawa University in Ottawa, Canada, where he received his MD degree in 1961. He interned at St. Joseph Hospital in Flint, Michigan and performed his General Surgery residency at McLaren Hospital in Flint, followed by a Urology residency at the Cleveland Clinic in Cleveland, Ohio. He practiced in Flint from 1966 until his retirement in 1995. Dr. Robitaille is remembered for performing the first kidney transplant in Genesee County. He served as the Chief of Surgery at Hurley Medical Center for many years. He was preceded in death by his wife, Beatrice in 2001. Contributions may be made to the Hurley Medical Center Cancer Fund.

Memories of
MAURICE ROBITAILLE, MD

Dr. Maurice Robitaille came to Flint and established his urology practice in 1965. He received his urology training at the Cleveland Clinic. Since Cleveland was also pioneering in kidney transplantation and dialysis, he received training in those specialties as well.

It was notable that Dr. Willem Kolff, inventor of dialysis, was also at the clinic for research and teaching at that time.

At Hurley, Maurice set up a protocol for both cadaver and family, live kidney transplants (identical twin transplants work the best and require the least amount of anti-rejection drugs). Around 1971, a cadaver kidney became available through the Michigan Kidney Transplant Society, and Dr. Robitaille performed Hurley's first transplant. The patient did well despite the barrage of anti-rejection drugs that were used at that time and he lived for about five years before succumbing to a heart attack. Many others followed this initial success. One of the sibling transplants were notable, of that period, she became the longest surviving patient in Michigan.

I worked closely with Maurice, because one of the nephrologist's jobs in those early days was to be in the operating room and help examine and prepare the new kidney for transplant, then hand it over to the surgeon – not a comfortable job for a non-surgical internist. (I was always afraid I would drop this slippery, but precious organ.)

Dr. Robitaille continued to do transplants and AV fistulas until his retirement in 1995. He was widely recognized as a skilled and meticulous surgeon and was always unfazed and tolerant of the frequent short notices involved in this surgery, seemingly always on Christmas Eve or New Year's Eve, when a kidney became available.

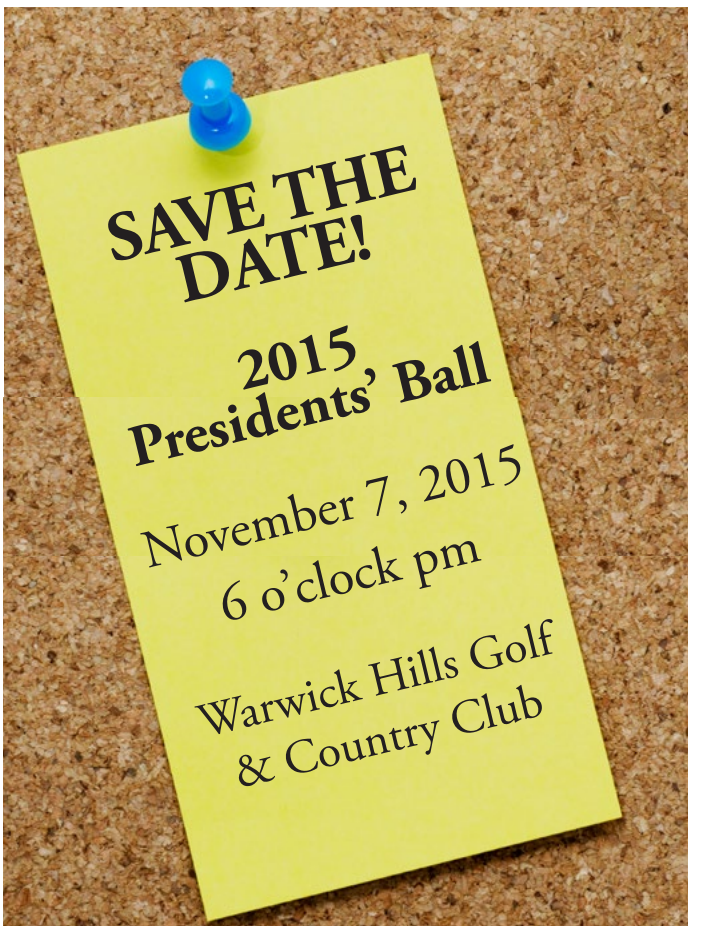
I am also indebted and grateful to him for the training and guidance I received from him, which formed my interest and pursuit for the subspecialty of nephrology.

Paul Schroeder, MD

Did you recognize...

Allen F. Turcke, MD

President, Medical Society Foundation
Past President, Genesee County Medical Society



Health System Transformation Will Challenge Physicians

By PAUL NATINSKY

The Patient Protection and Affordable Care Act has changed the way providers, payers and patients approach health care since its inception in 2010; Blue Cross and Blue Shield of Michigan has been transforming medical practices through its Physician Group Incentive Plan since 2005.

Dr. Thomas Simmer is the architect of the Blues' PGIP program. PGIP changes the way physicians traditionally have been paid to encourage "improved performance in health care delivery." The program relies on team-based care, information sharing, population health management and a concept called the Patient Centered Medical Home that embodies these principles. Dr. Simmer is a senior vice president with Blue Cross and Blue Shield of Michigan and the company's Chief Medical Officer.

PGIP also includes a revised payment scheme that has had many physicians scratching their heads since 2005. Payments under the program are structured to reward physicians for improving their patients' health and delivering efficient, cost effective care.

To accomplish this, BCBSM earmarks a portion of its fees for use as bonus payments to high-performing physician groups. This pool of money, currently about $100 million per year, is distributed to Physician Organizations. Leaders of those organizations determine whether to use the money to improve the PO overall, pass it along to member physicians, or both.

Separate from the group bonus payments are tiered uplift payments to individual physicians. These are enhanced payments from the Blues that do not come out of the PGIP pool money. The higher payment rates reward physicians who achieve benchmarks in their practices and physicians participating in POs that meet the standards. So strong individual practices are rewarded and strong individual practices in high performing POs are doubly rewarded. The tiered payment system is based on standards for physician specialties created by those specialties and approved by BCBSM.

In a Feb. 5 dinner meeting visit to the Genesee County Medical Society, Dr. Simmer lifted the hood and discussed PGIP's inner workings and underlying philosophies.

Dr. Simmer outlined what he called the "root cause issues" that characterize low health system performance. They include: poorly aligned payment, lack of population focus, fragmented health care delivery, a weak primary care foundation and lack of focus on process excellence.

"Our health care delivery system, if we really want it to achieve everything it can, really has to overcome these root cause issues," said Dr. Simmer.

"First of all, the payment policy has to change if we are going to change," he said. Payments should reward team-based care and move away from a fee-for-service model. "For us to have an effective system, we have to have a population management infrastructure. We have to be able to have a business plan where the financial success of the people delivering care is equated with better care outcomes. And we have to pay for things like health information exchange and data, in which the provider community is incurring very high costs, but (without) any significant reimbursement."

Dr. Simmer said progress is being made on the primary care front where, "we're fortunate that the worst days for primary care…are way behind us. Primary care has gone about strengthening its foundation through implementation of the chronic care model, the patient centered medical home and, most importantly, team-based care."

The Patient Centered Medical Home is the lynchpin for practice transformations under PGIP. The PCMH concept is not unique to the Blues, but its standards and requirements are specific to BCBSM and serve as the criteria for physician practices receiving designated PCMH status since the program's inception in 2009.

PCMH criteria strongly emphasize a team approach to coordinating patient care, with enhanced access to primary care services, a focus on managing chronic conditions to reduce hospitalizations and the use of electronic patient registries and reporting tools to better track and manage patient health.

The Blues report that the program saved $155 million in its first three years and estimates fourth-year savings at $100 million. In 2014, BCBSM awarded PCMH designation to more than 4,022 physicians in more than 1,420 practices in Michigan.

Dr. Simmer said PCMH practices in 2013 experienced 21.4 percent fewer emergency department visits for ailments that can be mitigated by early primary care intervention and had a 15.1 percent lower overall

emergency department visit rate than non-PCMH designated practices. He said all rates have improved over the 2013 PCMH designation year.

"Please don't get discouraged by how difficult all of this is because this is what (PCMH-designated physicians) have been able to do," said Dr. Simmer. "As patient centered medical homes, the things (physicians) did in (their) practices were not invented by Blue Cross, but were invented by physician societies—physicians prescribing an effective care model."

While progress is being made on many fronts, much work lies ahead. "Health information is going to be the next serious challenge," said Dr. Simmer. "Information is going to be arriving in your practice from the outside—information that you always thought you wanted to know. But now that you are getting it, you'll realize that it is overwhelming to deal with that information and use it effectively."

The nexus for much of this information transfer is the Michigan Health Information Network, a statewide electronic information sharing network that employs something called the Health Information Services Cloud to facilitate the safe sharing of information and data collection.

Dr. Simmer said the system organizes "active-care relationships" providers have with patients and routes it to providers based on their preferences.

"That term, 'active care relationship,' is going to be very important because every physician, specialist or primary care, is going to need to assemble that list, get that list sent to MIHIN. Then, when your patient receives a service at any hospital, emergency room or (other setting), that information is going to MiHIN. MiHIN will then match it against who your active care relationships are based on the information you supply. You will then get that information from MiHIN."

Dr. Simmer said close to 90 percent of hospital admissions and emergency room visits are in the system, but there is a long way to go with active care relationship information.

While changing the health care delivery world will require involvement from every corner of the health care system, Dr. Simmer envisions a primary role for physicians.

"We really want to support physician leadership," said Dr. Simmer. "We think that hospitals have a very important role to play, but they have a harder time understanding population management when their financial success is still incumbent on upon them filling beds.

"If we really want to have a high performing health care system under physician leadership, we need to focus in on infrastructure for population management, health information exchange so we're more informed and using a more effective, team-based model. All of those represent a huge challenge."

PLEASE NOTE: DR. SIMMER'S SLIDES AVAILABLE ON THE FOLLOWING PAGES

PGIP and Payment Update

February 5, 2015

Tom Simmer, M.D.
Senior Vice President and Chief Medical Officer

Abbreviations

- BCBSM Blue Cross Blue Shield - Michigan
- PGIP Physician Group Incentive Program
- PCMH Patient Centered Medical Home
- PCMHN Patient Centered Medical Home Neighbor
- MiPCT Michigan Primary Care Transformation Project
- MiHIN Michigan Health Information Network
- ACRE Active Care Relationship File
- HIE Health Information Exchange

It's got to come out of course, but that doesn't address the deeper problem.

A High Performance Healthcare System Addresses the root causes of low system performance	
Poorly aligned payment	Payment structure must strongly support a team-based care model, population management infrastructure, information exchange.
Lack of population focus	All-patient registries at the practice level, integrated registries at the ACO/ OSC level. Performance measured and rewarded at population level.
Fragmented health care delivery	Information sharing and process management connect participants in the care process. Common Care Plan.
Weak primary care foundation	Patient Centered Medical Home; Provider-Delivered Care Management
Lack of focus on process excellence	Collaborative Quality Initiatives Lean process redesign across settings of care.

Key Points

- BCBSM has moved from a volume-based payment model to performance based model
  - If physician practices want financial success, deliver better population level results rather than more services

- Population level results require
  - Population Management Infrastructure, including population registries
  - Proactive, team based care
  - Health information connected with the care process
  - Physician leadership, initiative and collaboration

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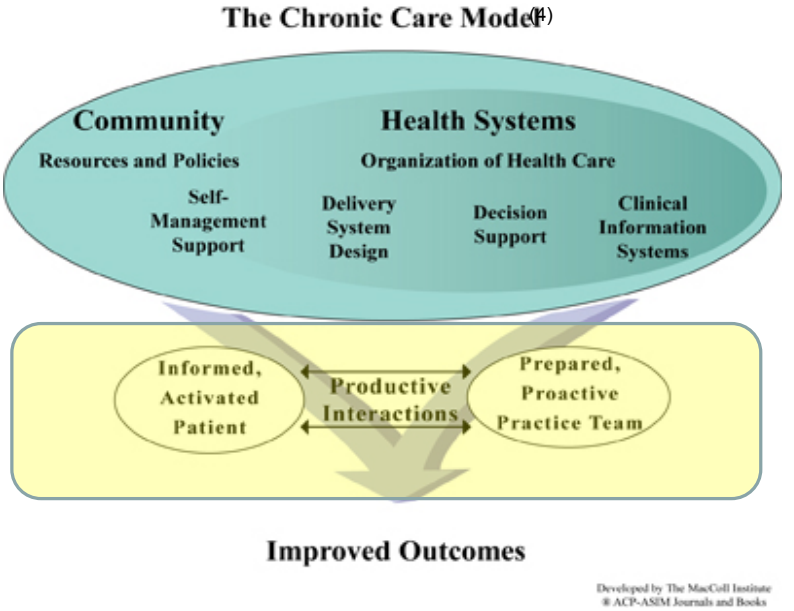
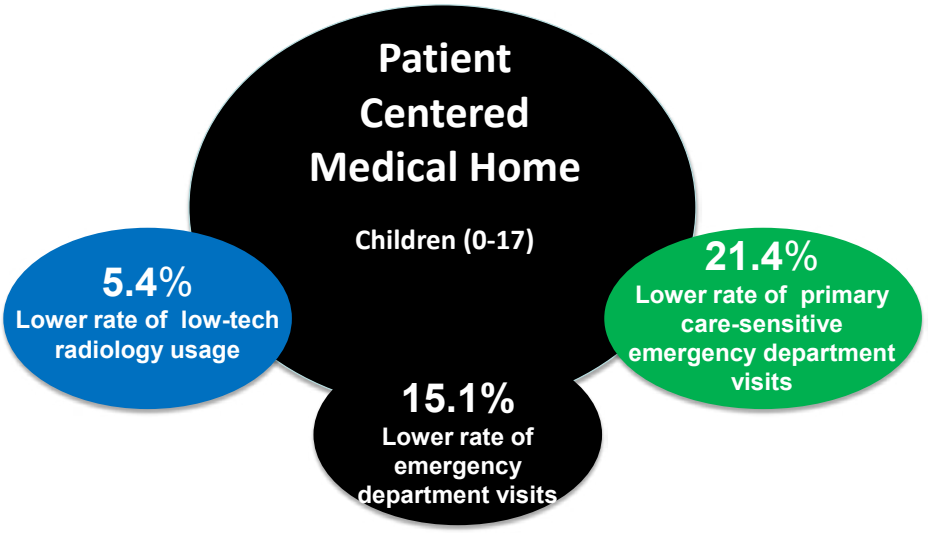
Coordinated, Pro-active Care Model



Pro-active, team based care is connected to all participants in the patients care and informed by population-based performance information.

6

Performance comparisons, for PCMH-designated practices as compared to non-PCMH designated



HCV Data Analytics, BCBSM, PCMH 2014 Designation: Final Results, 5/30/14, CY 2013

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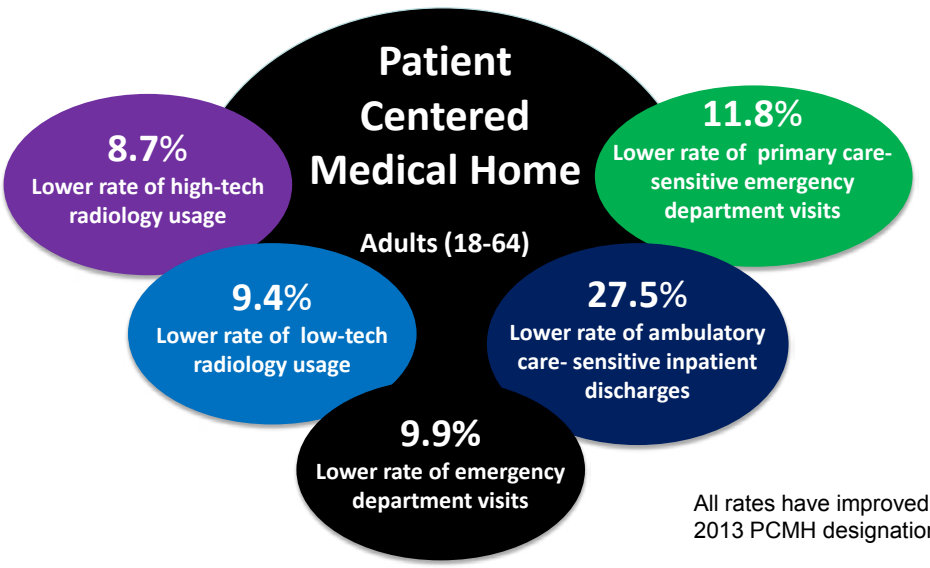
Performance comparisons, for PCMH-designated practices as compared to non-PCMH designated



All rates have improved over 2013 PCMH designation year

HCV Data Analytics, BCBSM, PCMH 2014 Designation: Final Results, 5/30/14, CY 2013

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Team Based Care: BCBSM Results

- BCBSM cost trend for MiPCT practices were lower than PGIP, non-MIPCT practices in both 2012 and 2013, inclusive of program costs.
  - In 2012, MiPCT medical cost trend was $0.48 PMPM, while non-MiPCT PGIP average was $0.72 PMPM.
  - In 2013, MiPCT medical cost trend was **negative** $0.07 PMPM while the PGIP average was positive $0.17 PMPM.
  - As with PCMH, performance shows continued improvement over time as practices get better at what they do. The impact so far is small, so the MiPCT model needs to evolve to have a greater impact.

9

Information Drives Population Health Strategies

Information management becomes a major core process within practices

Population Identification and Stratification

- Patient care relationships are clearly identified.
- Patient assessments inform population stratification efforts.

Care Coordination

- Patient portals become major route of patient-practice communication.
- Common care plans support coordination across settings of care.
- Shared information supports outreach and point of care interventions.

Network and Provider Reporting

- Transparent performance, cost, and utilization reporting drives referral patterns and payment.

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Care Manager Role Expands with Electronic Sharing of Clinical Information

All-Patient Registries

Patient Portal

Electronic-Prescribing

Health Information Exchange
Admission, Discharge and Transfers (ADT) notification

The Challenge of Information:

- **keeping information safe**
- **managing the information (sorting , distributing, storing, maintaining data integrity)**
- **acting on it (incorporating it into clinical process flow)**

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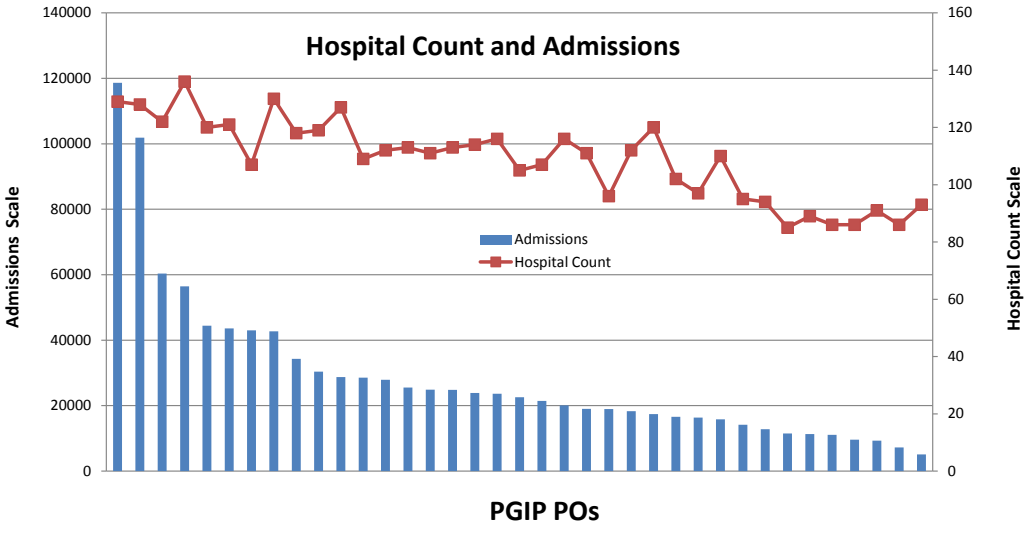
Why a "Statewide" Service?

Every PO has patients in numerous hospitals



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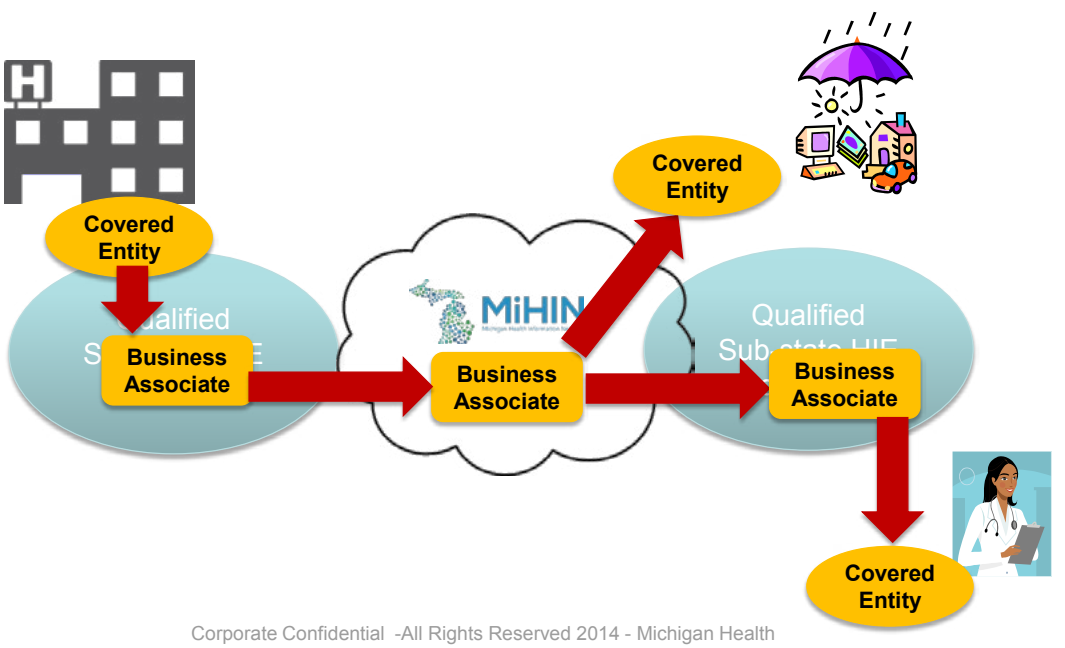
Sharing information Across Settings of Care

1) Source Information is sent from service provider (ADT, Lab, Image, Rx)
2) MiHIN matches patient and identifies three providers
3) MiHIN identifies a delivery preference for each provider
4) Notification is routed to the providers based on their preference

Clear Chain of Trust



Understand Tiered Fees

- Primary Care Physicians' Evaluation and Management fees range from 100 to 130 percent of the standard fee.
- Specialists' RVU based fees range from 100 to 110 percent of the standard fee.
- In all cases, the highest fee level is based on **how well the overall population in managed**, primarily risk adjusted per member cost, and, increasingly, quality (HEDIS, etc.) performance.

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Summary

- A High Performance Health Care System includes a pro-active, team-based, coordinated model of care, shared health information at point of care and for electronic patient outreach
- Success requires a payment model that supports the care management, information sharing, and population management infrastructure.
- The Patient Centered Medical Home model with Team-Based care management achieves better outcomes at a lower cost.
- BCBSM supports physician leadership in creating a high performance healthcare system in Michigan and promotes connectivity and coordination among all participants in the care process.

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Contact Information

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2014-15 State and Federal Elected Officials from Genesee County

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GENERAL NUMBER:
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34th District
Sheldon Neeley – D
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sheldonneeley@house.mi.gov

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repphelps@house.mi.gov

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SenDRobertson@senate.michigan.gov

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GOVERNOR / LT. GOVERNOR

Governor Rick Snyder – R
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(517) 335-7858
(Constituent Services)
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Lansing, MI 48909
FAX: (517) 335-6867

Lt. Governor Brian Calley – R
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P.O. Box 30013
Lansing, MI 48909
FAX: (517) 241-3956

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5th Congressional District of Michigan –
Congressman Daniel Kildee – D
(202) 225-3611
327 Cannon House Office Building
Washington, DC 20515-4320
FAX: (202) 225-6393
Flint Office: 810-238-8627
801 S. Saginaw Street, Plaza Level
Flint, MI 48502

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Senator Gary Peters – D
(202) 224-6221
SRC-2 Russell Senate Office Building
U.S. Senate
Washington, DC 20510

Detroit Office:
Patrick V. McNamara
Federal Building
477 Michigan Avenue
Suite 1860
Detroit, MI 48226
Phone: (313) 226-6020

Senator Debbie Stabenow – D
(202) 224-4822
133 Hart Senate Office Building
Washington, DC 20510-2204
FAX: (202) 228-0325
Flint Office:
(810) 720-4172
432 N. Saginaw Street, Suite 301
Flint, MI 48502
FAX: (810) 720-4178

HAPPY BIRTHDAY DOCTOR

Nathaniel Narten, MD	1	John Brady, MD	13	Mazin Saadaldin, MD	22
Srinivas Mukkamala, MD	1	Virgilio Villarreal, MD	13	Susumu Inoue, MD	23
Joseph Varghese, MD	2	Karsten Fliegner, MD	13	R. Roderic Abbott, MD	24
Anju Sawni, MD	2	Cory Cookingham, MD	14	Hina Javaid, MD	25
Sascha Knoblich, MD	2	Paul Karr, MD	14	Adiraj Singh, MD	25
Christopher Singh, MD	2	Suresh Anne, MD	14	James VanBrocklin, MD	26
Rama Rao, MD	4	James Neubeck, MD	16	Clinton Dowd, MD	26
Wendy Lawton, MD	4	Christie Samuels, MD	16	Harold Rutila, MD	26
Rizwan Danish, MD	5	Russell Sandberg, MD	17	Shagufta Ali, MD	26
Vijay Naraparaju, MD	5	Robert House, MD	19	Chang Lee, MD	27
Kristin Krizmanich-Conniff, MD	6	Silva Doyle, MD	19	Joseph Batdorf, MD	28
Ghassan Bachuwa, MD	8	Yaseen Hashish, MD	20	Shawky Hassan, MD	28
Robert Rosenbaum, MD	9	Gregory Harris, DO	20	Vikram Rao, MD	28
Dilip Desai, MD	9	David Gordon, MD	21	Jawad Shah, MD	28
Madan Arora, MD	10	Asif Ishaque, MD	21	Tomy Kalapparambath, MD	28
Frank Cook, MD	12	Tjin Lim, MD	22	Radhika Kakarala, MD	29
Charles Hennessy, MD	13	David Lee, MD	22	Elfateh Seedahmed, MD	30
		Abdul Alawwa, MD	22		

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by not-for-profit urgent care center. Please contact Brenda at bcraft@gcms.org or call (810) 232-2710.

Check Out Our Website www.gcms.org

GCMS MEETINGS

—March 2015 —

Legislative Liaison Committee, 2/2
8am, GCMS Office

Bulletin Committee, 3/4
7:30am, GCMS Office

C-Section Task Force, TBD
6pm, GCMS Office

MSF Fundraising Committee, 3/26
6pm, GCMS Office

Finance Committee, 3/24
5:30pm, GCMS Office

Board of Directors, 3/24
6pm, GCMS Office

Community & Environmental Health Committee, 3/25
12:30pm, GCMS Office

Practice Managers, 3/26
8am, GCMS Office

SAVE THE DATE!!! 2015 Presidents' Ball
November 7, 2015
6 o'clock pm at the
Warwick Hills Golf & Country Club

MSMS
MICHIGAN STATE MEDICAL SOCIETY

120 W. Saginaw Street • East Lansing, MI 48823
msms@msms.org • www.msms.org
517-336-5762 • Fax: 517-336-5797

Join MSMS online at
www.joinmsms.org

State & County Medical Society Membership Application

Application Code:

- ❑ I am in my 1st year of practice post-residency.
- ❑ I am in my 2nd year of practice post-residency.
- ❑ I am in my 3rd year of practice post-residency.
- ❑ I have moved into Michigan, and this is my first year practicing in the state.

- ❑ I work 20 hours or less per week.
- ❑ I am currently in active military duty.
- ❑ I am in full-active practice.

❑ Male ❑ Female

First (legal) Name: _____ Middle Name: _____ Last Name: _____ ❑ MD ❑ DO

Nickname or Preferred Form of Legal Name: _____ Maiden Name (if applicable:) _____

Job Title: _____

W Phone: _____ W Fax: _____ H Phone: _____ H Fax: _____

Cell: _____ Email: _____

Office Address ❑ Preferred Mail ❑ Preferred Bill ❑ Preferred Mail and Bill

_____

City: _____ State: _____ Zip: _____

Home Address ❑ Preferred Mail ❑ Preferred Bill ❑ Preferred Mail and Bill

_____

City: _____ State: _____ Zip: _____

* Please base my county medical society membership on the county of my (if addresses are in different counties): ❑ Office Address ❑ Home Address

* Birth Date: ____ / ____ / ____ Birth Country: _____ MI Medical License #: _____ ME #: _____

Medical School: _____ Graduation Year: _____ ECFMG # (if applicable): _____

Residency Program: _____ Program Completion Year: _____

Fellowship Program: _____ Program Completion Year: _____

Hospital Affiliation: _____

• Primary Specialty: _____ Board Certified: ❑ Yes ❑ No

• Secondary Specialty: _____ Board Certified: ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced Spouse's First Name: _____ Spouse's Last Name: _____

Is your spouse a physician?: ❑ Yes ❑ No If yes, are they a member of MSMS?: ❑ Yes ❑ No

Within the last five years, have you been convicted of a felony crime?: ❑ Yes ❑ No If "yes", please provide full information: _____

_____

_____

Within the last five years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?: ❑ Yes ❑ No If "yes", please provide full information:

_____

_____

Within the last five years, have you been the subject of any disciplinary action by any medical society or hospital staff?: ❑ Yes ❑ No If "yes", please provide full information:

_____

_____

I agree to support the County Medical Society Constitution and Bylaws, the Michigan State Medical Society Constitution and Bylaws, and the Principles of Ethics of the American Medical Association as applied by the AMA and the MSMS Judicial Commission.

Signature: _____ Date: _____

When completed, please mail to MSMS or Fax to (517) 336-5797. Thank you!

County Medical Society Use Only
Reviewed and Approved by

_____

_____