In any crisis it’s important to learn the facts from experts to ensure the safety of you and your family. Working together with The Bronx Chamber of Commerce, The DOH, we have organized a forum to educate the public on the Ebola & Enterovirus epidemics. Working with experts, we can make sure to keep our patients and communities safe while navigating how to tackle these dangerous diseases.

**Tuesday, December 2, 2014 – 5:00 PM – 7:30 PM**
Legislative HealthCare Forum – Dinner Meeting at the Hutchinson Metro Conference Center & Metro Café
1200 Waters Place, Bronx, NY 10461

**RSVP** – Space is limited – Deadline to Register is November 30th
Register via email bxcms@msn.com (or) Fax – 718 823-4505 Please include Your Name, Address & Contact Telephone:

**As of November 1, 2014**
Our office Headquarters has moved to the following location: Note the new telephone & fax numbers as well

Bronx County Medical Society
Diane P. Miller, Executive Director
3058 East Tremont Avenue
Bronx, NY 10461
Tel: 718 823-4500
Fax: 718 823-4505
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Avoiding an OPMC/OPD Interview Whenever Possible
You may have noticed an uptick in oversight this past year, which seemingly has included the number of OPMC and OPD licensure matters investigated. For those unfamiliar, OPMC and OPD are the arms of the NYS Department of Health responsible for policing licensed professionals. The purview of each department is to "protect the public" essentially from harmful practitioners. A licensure action may be commenced as a result of patient complaint, complaint by a competitor, reporting from another department or malpractice action result or the whim of an investigator (this does happen, i.e., Groupon inquiries).

Most licensure investigations are initiated by letter to the subject practitioner vaguely describing the issue under review and requesting an interview by the investigator and the practitioner. At this stage most practitioners know they should have legal counsel and should not be communicating with licensure themselves. But, what else should they know? What most lawyers will not tell you, and by practice do not employ, is that under most circumstances, any and all contact between you, including that initial interview (or any interview) should be avoided. You see, OPMC and OPD have tremendous flexibility in their purview and oversight, and a complaint wherever originating, may be viewed as the window in to a potential problem practitioner. Allowing the investigator free range to question and prod allows the investigator to potentially expand (explode) the scope of the inquiry. Many attorneys will not caution or warn against attending because, frankly, attending often leads to more work defending for the lawyer. Many practitioners are unaware of this result and go by counsel's advice. Counsel may in fact be the firm assigned by your insurance carrier - so of course, you assume you should trust their advice.

The prudent practitioner with competent counsel avoids an interview at all costs. Of course there may be circumstances where the situation may best be addressed by an in person review, but those instances are few and further between as the concern of client protection and limiting access is a main priority. In fact, many licensure inquiries can be resolved without an interview and without interaction by the practitioner and the government agency.

Looking for counsel to help defend against OPMC or OPD, contact Jennifer at 516 747 6700 x. 302 or at Jennifer@kirschenbaumesq.com. K&K is a proud member of the MLMIC licensure defense panel.

Member in the News
HHS Chief Technology Officer, Bryan Sivak and his team came to visit Essen Medical Associates Office back in September. Essen is doing a pilot project with CMS-ONC to improve ‘ADT’ (Admission, Discharge and Transfer) communication between hospitals and community providers.

ICD-10 Resources Spotlight: Road to 10
Looking for help planning and executing your ICD-10 transition?
The Centers for Medicare & Medicaid Services (CMS) has developed the Road to 10, a free online resource built with the help of physicians in small practices. Available on the Provider Resources page at cms.gov/ICD10, this tool is intended to help small medical practices jumpstart their ICD-10 transition. The Road to 10 can help you:
Understand the basics of ICD-10
Build an ICD-10 action plan to map out your transition
Answer frequently asked questions
Learn how ICD-10 affects your practice with tailored clinical scenarios and documentation tips for Family Practice and Internal Medicine, Obstetrics and Gynecology, Orthopedics, Cardiology, and Pediatrics
The Road to 10 is regularly updated, so check back frequently for new information.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.
CMS TO PAY DOCS FOR CARE COORDINATION
TELEHEALTH
By Melanie Evans  |  October 31, 2014
Doctors will be paid for Medicare care coordination, wellness and behavioral health telehealth visits. But, under final rules issued by the CMS late Friday, physicians also could see all Medicare payments cut by roughly 21% in April if the Medicare sustainable growth rate formula cuts are allowed to take effect.
In addition, the rule eliminates a controversial reporting exemption under the Physician Payments Sunshine Act for indirect financial ties between industry and physicians. It expands quality-performance penalties to all doctors. And it contains new quality criteria for the Medicare Shared Savings Program, a test of the accountable care payment and delivery model that now includes more than 300 accountable care organizations.
As proposed earlier this year, Medicare will cover wellness and behavioral health telehealth visits starting in January, according to the final rule for Medicare's physician fees. Doctors also will be able to bill Medicare $40 per patient per month for care coordination for patients with multiple chronic conditions. The new payments are for non-face-to-face services.
Under the rule, the Medicare sustainable growth rate formula—a payment policy that has forced Congress to repeatedly intercede to avoid major cuts to physician payment—would slash reimbursement to doctors by 21.1% as of April 1.
The rule also affects reporting of manufacturers' payments to physicians under the Sunshine Act. The CMS originally had proposed exempting payments to physicians associated with accredited continuing medical education from payments that must be reported to the CMS' Open Payments website. That reporting is intended to inform the public about physicians' possible conflicts of interest.
But the CMS reversed course in July and proposed to eliminate that exemption and require reporting of these payments. Friday's rule finalized the elimination of the exemption for reporting indirect manufacturers' payments to physicians for continuing medical education participation.
According to the CMS, applicable manufacturers and group purchasing organizations now will be required to report compensation provided to physician speakers at continuing education events, unless the payment or other transfer of value is specifically excluded.
Eliminating the exemption for payments to speakers at certain accredited or certifying continuing medical education events will create a more consistent reporting requirement, and will also be more consistent for consumers who will ultimately have access to the reported data," the CMS said in an overview of the rule changes.

The Sunshine Act-related rule provision also clarifies which indirect subsidies must be reported when the industry underwrites CME for doctors. Underwriting by drug and medical-device makers won't be considered indirect payments as long as the grants meet established criteria, including that recipients of the underwriting, not the manufacturers, have control over content of events and which doctors receive subsidies.

Andrew Rosenberg, senior adviser for the CME Coalition, a lobbying group for accredited CME providers, called this CMS clarification a victory for his members. "This clarification by CMS addresses the chief concerns of the CME Coalition and over 98% of the commenters to the public record who called on the agency to maintain a strong CME exemption to the reporting requirements," he said in an e-mail.

The rule also included significant changes to Medicare payments tied to quality under the health reform law. Next year, Medicare payment to all physicians will be adjusted by quality performance under value-based payment modifiers. The quality-performance penalties were previously limited to larger groups and excluded small practices.

The rule also contained new quality criteria for the Medicare Shared Savings Program, a test of the accountable care payment and delivery model that now includes more than 300 accountable care organizations.

The proposed rule would have increased quality measures to 37 from 33. The final rule will limit the quality measures to 33, but with changes. The CMS will add new measures for stewardship of patient resources; 30-day, all-cause skilled nursing facility readmissions; and all-cause unplanned admissions for patients with diabetes, heart failure and multiple chronic conditions.
The rule also will add new measures for diabetic foot exams and three coronary-artery disease quality measures and remove six measures, including reconciliation of medications after patients leave the hospital.

In addition, the rule includes a bonus for Medicare Shared Savings ACOs that improve their quality performance. The current criteria award bonuses based on quality scores, not quality improvement.
Herbal Products and Supplements in Medicine
Saideh Farahmandnia, MD & Shervin Mortazavi, MD

Many dietary supplements are safe and designated to improve health by supplying nutrients missing in foods. With the growing interest many books, “Prescription for Nutritional healing” or “Encyclopedia of Nutritional supplements” have been published to educate the public about supplements to restore or maintain good health. At times patients are unsure weather to take a prescription or a supplement. They ask their physicians, who may or may not be educated about supplements and how they interact with prescription meds. Medical professionals hear questions such as “I cannot take this statin drug anymore; is there an alternative in supplements? or, will Ginkgo Biloba improve my memory?”

Supplements are not analyzed by the Food and Drug Administration (FDA) before being sold. The supplements from different countries can be on market as long as the “supplemental fact” is submitted to FDA (FDA, 2013). The lack of analyze by FDA could result in there being no accurate fact about the supplements which have long been on the market. Sometimes there are risks involving harmful results or false claims about treatment and cures with help of supplements. These could result in recall after being on market and consumed by the public. In June 2014, the FDA announced that products with bee pollen for losing weight are dangerous by increasing heart rate and blood pressure (FDA, 2014). Another known example is Gingko Biloba which had a reputation of improving memory. In the randomized study published 2009 by the Journal American medical association, 3069 individual at age 75 or older without signs of dementia or had mild cognitive impairment took Ginko Biloba extract 120 mg twice daily or placebo. The follow up was done every six months for six years. The result indicated Gingko Biloba did not reduce the risk of dementia, hazard ratio 1.12, 95% CI (0.94 -1.33) (Snitz et al., 2009).

However in recent years we have seen the formation of large clinical trials to investigate the relationship between diet and disease. Dementia has been one of the largest challenges, with 44 million cases world-wide (ALZ, 2013) which is expected to drastically increase with rapid growth of aging population. For the first time in largest study published in 2014 in medical journal of the American Academy of Neurology indicated a link between low Vitamin D level and the risk of dementia and Alzheimer’s disease. The study performed on 1,658 adults who averaged 74 years old, did not have dementia and had no history of stroke or cardiovascular when study began. After five and half years, 171 people were diagnosed with dementia which included 102 with Alzheimer’s disease. The hazard ration for incidence of all the cause of dementia were 2.25 (CI 95%) who were severely deficient in vitamin D less than 25 nmol/l and deficient >25 to <50 nmol/l. The correlation of low vitamin D collected on blood samples where twice as likely to have developed dementia vs. people with normal level of vitamin D. This research also concluded that as the level of vitamin D dropped the risk for dementia and Alzheimer’s triple in sever vitamin deficiency (Littlejohns et al., 2014).

Also, low vitamin D also has been linked to the MS activity and its progression. Studied published by JAMA neurology, in 2014 performed a randomized study on 466 MS patients on beta-1b treatment, correlating level of vitamin D and MS activity. At higher level of vitamin D 50-nmol/l within first 12 months predicted lower rate of new active lesion by 57% (p<0.001), relapse rate dropped by 57% (p= 0.3), and yearly increase in T2 lesion volume drop by 25% (p<0.001) and yearly brain loss dropped by 0.41% (p=0.7). Data were collected from 12 to 60 months, which correlated with the date from 24 months to 60. (Slomski, 2013)

Currently most of the clinical trials on supplements helped us in preventive medicine. In recent years with this growing interest some physicians have began to educate public about supplements, which also could result in taking advantage of their education and expertise for marketing. Dr. Mercola and Dr. Oz are two examples of these cases that have been asked by FDA or government about the accuracy of some supplements and the facts involving treatment and cure.

Conclusion:
Alternative medicine is going under clinical trial and scientific studies progressively and we are on the way to new discoveries that might change the face of current medicine or bring about a new phase of integrative medicine. As of now, we have a lot more choices with conventional medications that are known as evidence based medicine to help patients in diagnosis, treatment and cure. There is always some disadvantage to use of conventional drugs due to their side effect. The final decision is made by the patient who has to decide between conventional medications vs. alternative choices. There might come a day that clinicians have more scientifically proven evidence on alternative options to guide patient’ choices.

References


Risk Management Tips: Prescription Medications and Patient Safety
The Tip: Educating patients about their prescription medications and keeping medical records updated with prescription information both help to ensure patient safety.
The Risk: Patient injuries and malpractice claims can result from known risks and side effects, allergic reactions, drug interactions or errors in prescribing.
Recommendations: MLMIC offers the following guidelines/suggestions to physicians and dentists regarding prescription medications and patient safety. Since there are significant risks and side effects associated with prescribed drugs, physicians and dentists must discuss this information with their patients and document these discussions in the medical record.
The patient’s allergic history must be reviewed before a new drug is prescribed. Known allergies must be documented and flagged in a prominent, easily viewable place in the medical record.
Medication updates, including dosage changes and refills, and the use of any over-the-counter drugs, must be clearly documented in the medical record. A medication flow sheet can be used to monitor and track current and past medication usage, as well as allergies. Any specific instructions provided to patients regarding the medications must also be written in the record. There must be written confirmation that the laboratory and/or diagnostic tests necessary to monitor certain drugs for their effectiveness or side effects are ordered, as recommended by professional guidelines, and the test results viewed and necessary adjustments made. The rationale for the discontinuing a medication must be documented in the medical record.
Risk Management Tips provide guidance to support our physicians and facilities in their ongoing efforts to improve the quality of patient care and reduce liability exposure in the practice of medicine.
Please contact MLMIC’s Risk Management Department at (800) 275-6564, weekdays 9:00 AM – 5:00 PM, for guidance regarding your specific situation.

Why Doctors Are Sick of Their Profession
American physicians are increasingly unhappy with their once-vaulted profession, and that malaise is bad for their patients
By Sandeep Jauhar
Dr. Jauhar is director of the Heart Failure Program at the Long Island Jewish Medical Center. This essay is adapted from his new book, “Doctored: The Disillusionment of an American Physician,” published by Farrar, Straus and Giroux.
All too often these days, I find myself fidgeting by the doorway to my exam room, trying to conclude an office visit with one of my patients. Many of my colleagues are similarly struggling with the loss of their professional ideals. It could be just a midlife crisis, but it occurs to me that my profession is in a sort of midlife crisis of its own. In the past four decades, American doctors have lost the status they used to enjoy. In the mid-20th century, physicians were the pillars of any community. If you were smart and sincere and ambitious, at the top of your class, there was nothing nobler or more rewarding that you could aspire to become. Today medicine is just another profession, and doctors have become like everybody else: insecure, discontented and anxious about the future. In surveys, a majority of doctors express diminished enthusiasm for medicine and say they would discourage a friend or family member from entering the profession. In a 2008 survey of 12,000 physicians, only 6% described their morale as positive. Eighty-four percent said that their incomes were constant or decreasing. Most said they didn’t have enough time to spend with patients because of paperwork, and nearly half said they planned to reduce the number of patients they would see in the next three years or stop practicing altogether. American doctors are suffering from a collective malaise. We strove, made sacrifices—and for what? For many of us, the job has become only that—a job.
That attitude isn’t just a problem for doctors. It hurts patients too. Consider what one doctor had to say on Sermo, the online community of more than 270,000 physicians: “I wouldn’t do it again, and it has nothing to do with the money. I get too little respect from patients, physician colleagues, and administrators, despite good clinical judgment, hard work, and compassion for my patients. Working up patients in the ER these days involves shotgunning multiple unnecessary tests (everybody gets a CT!) despite the fact that we know they don’t need them, and being aware of the wastefulness of it all really sucks the love out of what you do. I feel like a pawn in a moneymaking game for hospital administrators. There are so many other ways I could have made my living and been more fulfilled. The sad part is we chose medicine because we thought it was worthwhile and noble, but from what I have seen in my short career, it is a charade.” The discontent is alarming, but how did we get to this point? To some degree, doctors themselves are at fault. In the halcyon days of the mid-20th century, American medicine was also in a golden age. Life expectancy increased sharply (from 65 years in 1940 to 71 years in 1970), aided by such triumphs of medical science as polio vaccination and heart-lung bypass. Doctors largely set their own hours and determined their own fees. Popular depictions of physicians (“Marcus Welby,” “General Hospital”) were overwhelmingly positive, almost heroic. American doctors at midcentury were generally content with their circumstances. They were prospering under the private fee-for-service model, in which patients were covering costs out of pocket or through fledgling private insurance programs such as Blue Cross/Blue Shield. They could regulate fees based on a patient’s ability to pay and look like benefactors. They weren’t subordinated to bureaucratic hierarchy. After Medicare was introduced in 1965 as a social safety net for the elderly, doctors’ salaries actually increased as more people sought medical care. In 1940, in inflation-adjusted 2010 dollars, the mean income for U.S. physicians was about

CONTINUE
$50,000. By 1970, it was close to $250,000—nearly six times the median household income. But as doctors profited, they were increasingly perceived as bilking the system. Year after year, health-care spending grew faster than the U.S. economy as a whole. Meanwhile, reports of waste and fraud were rampant. A congressional investigation found that in 1974, surgeons performed 2.4 million unnecessary operations, costing nearly $4 billion and resulting in nearly 12,000 deaths. In 1969, the president of the New Haven County Medical Society warned his colleagues “to quit strangling the goose that can lay those golden eggs.” If doctors were mismanaging their patients’ care, someone else would have to manage that care for them. Beginning in 1970, health maintenance organizations, or HMOs, were championed to promote a new kind of health-care delivery built around price controls and fixed payments. Unlike with Medicare or private insurance, doctors themselves would be held responsible for excess spending. Other novel mechanisms were introduced to curtail health outlays, including greater cost-sharing by patients and insurer reviews of the necessity of medical services. That ushered in the era of HMOs. In 1973, fewer than 15% of physicians reported any doubts that they had made the right career choice. By 1981, half said they would not recommend the practice of medicine as highly as they would have a decade earlier. Public opinion of doctors shifted distinctly downward too. Doctors were no longer unquestioningly exalted. On television, physicians were portrayed as more human—flawed or vulnerable (“The St. Elsewhere”) or professionally and personally fallible (“ER”). As managed care grew (by the early 2000s, 95% of insured workers were in some sort of managed-care plan), physicians’ confidence plummeted. In 2001, 58% of about 2,000 physicians questioned said that their enthusiasm for medicine had gone down in the previous five years, and 87% said that their overall morale had declined during that time. More recent surveys have shown that 30% to 40% of practicing physicians wouldn’t choose to enter the medical profession if they were deciding on a career again—and an even higher percentage wouldn’t encourage their children to pursue a medical career. There are many reasons for this disillusionment besides managed care. One unintended consequence of progress is that physicians increasingly say they don’t have enough time to spend with patients. Medical advances have transformed once‐terminal diseases—cancer, AIDS, congestive heart failure—into complex chronic conditions that must be managed over the long term. Physicians also have more diagnostic and treatment options and must provide a growing array of screenings and other preventative services. At the same time, salaries haven’t kept pace with doctors’ expectations. In 1970, the average inflation‐adjusted income of general practitioners was $185,000. In 2010, it was $161,000, despite a near doubling of the number of patients that doctors see a day. While patients today are undoubtedly paying more for medical care, less of that money is actually going to the people who provide the care. According to a 2002 article in the journal Academic Medicine, the return on educational investment for primary‐care physicians, adjusted for differences in number of hours worked, is just under $6 per hour, as compared with $11 for lawyers. Some doctors are limiting their practices to patients who can pay out of pocket without insurance company discounting. Other factors in our profession’s woes include a labyrinthine payer bureaucracy. U.S. doctors spend almost an hour on average each day, and $83,000 a year—four times their Canadian counterparts—dealing with the paperwork of insurance companies. Their office staffs spend more than seven hours a day. And don’t forget the fear of lawsuits; runaway malpractice‐liability premiums; and finally the loss of professional autonomy that has led many physicians to view themselves as pawns in a battle between insurers and the government. The growing discontent has serious consequences for patients. One is a looming shortage of doctors, especially in primary care, which has the lowest reimbursement of all the medical specialties and probably has the most dissatisfied practitioners. Try getting a timely appointment with your family doctor; in some parts of the country, it is next to impossible. Aging baby boomers are starting to require more care just as aging baby boomer physicians are getting ready to retire. The country is going to need new doctors, especially geriatricians and other primary care physicians, to care for these patients. But interest in primary care is at an all‐time low. Perhaps the most serious downside, however, is that unhappy doctors make for unhappy patients. Patients today are increasingly disenchanted with a medical system that is often indifferent to their needs. People used to talk about “my doctor.” Now, in a given year, Medicare patients see on average two different primary care physicians and five specialists working in four separate practices. For many of us, it is rare to find a primary physician who can remember us from visit to visit, let alone come to know us in depth or with any meaning or relevancy. Insensitivity in patient‐doctor interactions has become almost normal. I once took care of a patient who developed kidney failure after receiving contrast dye for a CT scan. On rounds, he recalled for me a conversation he’d had with his nephrologist about whether his kidney function was going to get better. “The doctor said, ‘What do you mean?’” my patient told me. “I said, ‘Are my kidneys going to come back?’ He said, ‘How long have you been on dialysis?’ I said, ‘A few days.’ And then he thought for a moment and said, ‘Nah, I don’t think they’re going to come back.’” My patient broke into sobs. “Nah, I don’t think they’re going to come back.” That’s what he said to me. Just like that.” Of course, doctors aren’t the only professionals who are unhappy today. Many professions, including law and teaching, have become constrained by corporate structures, resulting in loss of autonomy, status, and respect. But as the Princeton sociologist Paul Starr writes, for most of the 20th century, medicine was “the heroic exception that sustained the waning tradition of independent professionalism.” It is an exception whose time has expired. How can we reverse the disillusionment that is so widespread in the medical profession? There are many measures of success in medicine: income, of course, but also creating attachments with patients, making a difference in their lives and providing good care while responsibly managing limited resources. The challenge in dealing with physician burnout on a practical level is to create new incentive schemes to foster that meaning: publicizing clinical excellence, for example (public reporting of surgeons’ mortality rates or physicians’ readmission rates is a good first step), or giving rewards for patient satisfaction (physicians at my hospital now receive quarterly reports that tell us how our patients rate us on measures such as communication skills and the amount of time we spend with them). We also need to replace the current fee‐for‐service system with payment methods such as bundled payment, in which doctors on a case are paid a lump sum to divide among themselves, or pay for performance, which offers incentives for good health outcomes. We need systems that don’t simply reward high‐volume care but also help restore the humanism in doctor‐patient relationships that have been weakened by business considerations, corporate directives and third‐party intrusions. I believe most doctors continue to want to be like the physician knights of the golden age of medicine. Most of us went into medicine to help people. We want to practice medicine the right way, but too many forces today are propelling us away from the bench or the bedside. No one ever goes into medicine to do unnecessary testing, but this sort of behavior is rampant. The American system too often seems to promote knavery over knighthood. Fulfillment in medicine, as with any endeavor, is about managing hopes. Probably the group best equipped to deal with the changes wracking the profession today is medical students, who are not so weighed down by great expectations. Doctors ensconced in professional midlife are having the hardest time. In the end, the problem is one of resilience. American doctors need an internal compass to navigate the changing landscape of our profession. For most doctors, this compass begins and ends with their patients. In surveys, most physicians say the best part of their jobs is taking care of people. I believe this is the key to coping with the stresses of contemporary medicine: identifying what is important to you, what you believe in and what you will fight for. Medical schools and residency programs can help by instilling professionalism early on and assessing it frequently throughout the many years of training. Introducing students to virtuous mentors and alternative career options, such as part‐time work, may also help stem some of the burnout.

What’s most important to me as a doctor, I’ve learned, are the human moments. Medicine is about taking care of people in their most vulnerable states and making yourself somewhat vulnerable in the process. Those human moments are what others—the lawyers, the bankers—envy about our profession, and no company, no agency, no entity can take those away. Ultimately, this is the best hope for our professional salvation.
The overuse of U.S. Emergency Departments (EDs)
Aghavan Sadeghi Zangeneh, MD & Shervin Mortazavi, MD

Every year millions of Americans receive care or all of their primary healthcare in the Emergency Departments. One in every five Americans has at least one visit to the ED per year (1). From 1999 through 2011, the number of ED Visits increased from 365 to 415 per 1,000 persons, an increase of 13.7%. (2) Emergency care represents about 4% of all health care spending in the United States. Between 2000 and 2010, the mean expense for emergency department visits that did not result in hospital admission increased 77%, from $546 (in 2010 dollars) to $969 (3, 4). Non-emergent emergency department (ED) visits are typically defined as visits for conditions for which a delay of several hours would not increase the likelihood of an adverse outcome (5, 6). Seventy-one percent of emergency department visits are unnecessary or could have been avoided. Based on data in the commercial Truven Health MarketScan database in 2013, 29% of ED visits required emergency care and were not preventable, according to the study. Of the remaining 71% of ED visits, 42% required immediate attention for conditions that could have been safely treated in a primary care setting, 24% did not require immediate attention and 6% required emergency care that could have been avoided with appropriate primary care (7). It is estimated that more than $18 billion could be saved annually if those patients whose medical problems are considered “avoidable” or “non-urgent” were to take advantage of primary or preventive health care and not rely on EDs for their medical needs (8). In addition, this puts EDs under tremendous strain, and limits their ability to more quickly attend to health emergencies, reduce quality of care; overtreatment may pose another threat to the quality of ED care for non-emergent conditions. Because they are expected to make an accurate diagnosis and provide effective treatment based on a single visit and increase in hospitals diverting ambulances to other hospitals because of emergency department crowding (9, 10).

Reasons for Unnecessary ED Visits The main reason is that hospital EDs are required by federal law to provide care to all patients, regardless of health insurance status or ability to pay. Conveniently, the ED is always open, most ED users do not have a usual source of care, lack of access to other health care providers, shortages of primary-care physicians (PCPs) in some areas of the country, according to the U.S. Government Accountability Office (GAO) (11-14). About 12.5% of all ED visits are due to mental health and/or substance abuse treatment needs (15).

Reducing unnecessary ED visits Having and using a primary care provider results in better quality of care, health centers have implemented some strategies that enhance access to primary health care. 1) Emergency department diversion, divert emergency department patients by identifying and educating them on the appropriate use of the emergency department and the services offered at the health center. 2) Improving care coordination team to contacts the patient, to determine underlying issues that drive inappropriate ED use, and encourage patients to first seek care at the health center and connects the patient to the most appropriate, cost-effective services and resources for their condition. 3) A collaboration between primary Care Providers (PCPs) and local hospitals for individuals with chronic conditions can increase the use of primary care to manage their illness. 4) Accessibility of services provided evening and weekend hours and providing same-day or walk-in appointments. 5) Home care medicine (House Calls Program) for homebound population, decreases the number of ED visits. 6) QuickSeeMD’s web-based tool provides alternatives to the ED by giving users the locations of nearby clinics and physician practices based on where they live (14, 16, 17). There are a number of examples of effective interventions for reducing unnecessary ED visits in different states: The Washington State Medical Association, and the Washington State Hospital Association offer suggestions to save health care costs by reducing Emergency Department visits for narcotic-seeking behavior through generating statewide narcotic prescribing guidelines, increasing access to primary care and reducing Emergency Room visits by use of next-day or same-day visits to primary care, creating and implementing a prescription monitoring program, instituting a case management program to reduce Emergency Room utilization by frequent users (18). In Illinois State, an ED-based study reported on a randomized trial, finding a reduction in ED visits and hospitalizations a Housing and Case Management Program for patients who are homeless with chronic medical illnesses decreased ED use by 24% (19). In New York State, New Haven Community Health Care Van (CHCV) by using Case Management Progrm and a Mobile Health Clinic for IV drug users decreased ED use by 20% (20). Ohio State by using 24-hour help lines, saved more than $1.7 million in the first 18 months of operation (21).

Conclusion Many emergency department visits for nonemergency conditions or conditions preventable through outpatient care. In many cases, a simple phone call to a primary care office might be enough. We can improve health outcomes, quality of life and decrease costs through reduced inappropriate ED use. We have identified several strategies, but it will require a multifaceted approach; teamwork among health care funders, regulators, health care professionals, home care medicine, and Emergency Departments.

FOR LISTINGS OF ALL REFERENCES PLEASE CONTACT
Shervin Mortazavi, MD
Essen Medical Associates, PC
(718) 299-7295 shmortazavi@yahoo.com
2015 ANNUAL DUES STATEMENTS

Invoices for 2015 Annual Dues were sent to the membership on August 29, 2014

If you did not receive an invoice please contact the BCMS Office: Telephone: 718 823-4500 or Email: bxcms@msn.com

Members are asked to submit their dues in a timely fashion - on or before January 1, 2015.

***Remember to use the new mailing address 3058 East Tremont Avenue, Bronx, NY 10461

Now more than ever, we must all work together for the future of organized medicine.

Medical societies and specialty societies across the country are witnessing a constant erosion of their membership base, due in large part to physician apathy. With the dominance of managed care into what was once a “sacred” fee-for-service health care delivery system, physicians are unfortunately looking at membership in THEIR professional organizations from a purely financial (cost of dues) perspective, ignoring the obvious — their inability, as individuals, to help effectuate any meaningful change. As witnessed in the political, social and economic environments which encompass our daily lives, the stronger the voice, the better the chances of success. As organizations weaken through loss of membership, they lose their public credibility, influence and clout. Eventually, they will reach the point where they can no longer deal effectively with those elements that seek to control every aspect of medicine. I urge you to please continue your membership in the Bronx County Medical Society and MSSNY. Encourage your colleagues to join us. ..

New Study Validates Importance of Limits on Non-Economic Damages

A recent study published in Health Affairs validates what pro-liability reform supporters have been pushing policymakers to enact for decades — reasonable limits on non-economic damages — which result in lower costs for patients across the country. The authors of the study, titled “Medical Malpractice Reform: Noneconomic Damages Caps Reduced Payments 15 Percent, With Varied Effects By Specialty,” analyzed a sample of liability claims from 1985 through 2010 in parallel with information on state liability reforms, to estimate the impact of state limits on non-economic damages on average liability payments. The results compared how the liability payments differed as the limits increased from $250,000 to $500,000. “We found that, overall, noneconomic damage caps reduced average payments by $42,980 (15 percent), compared to having no cap at all,” stated study authors Seth A. Seabury, Eric Helland and Anupam B. Jena. “A $250,000 cap reduced average payments by $59,331 (20 percent), and a $500,000 cap had no significant effect, compared to no cap at all.” The study also touched on a real-time medical liability issue — the California ballot initiative to raise limits on non-economic damages in excess of $1 million. “…Our findings suggest that [passage of Proposition 46] would lead to about a 20 percent increase in average indemnity payments, with larger increases in obstetrics and gynecology and in pediatrics.” Enacting reasonable limits on non-economic damages, both at the state and federal levels, ensure that personal injury lawyers are prevented from abusing the medical liability system with meritless lawsuits, deserving patients are efficiently compensated, and health care services are both affordable and accessible to all patients.

Liability Rates Peak and Plateau

While medical liability insurance rates as a whole remained unchanged over the past year, it is clear from the Medical Liability Monitor Annual Rate Survey that this plateau follows years of stark increases and leaves physicians and patients concerned about access to affordable care in the future. Of the rates quoted in the survey, 65 percent did not change from 2013. For the remainder, rate decreases outnumbered rate increases. When taking into account rates in California, where MICRA first set the medical liability reform standard in 1975, and New York, which has so far failed to pass liability reforms and has seen an exodus of physicians, the differences are stark. Standard liability insurance rates for Long Island obstetrician/gynecologists top $210,000, but the rates in central California, where a physician can find the lowest standard rate in the country, are a fraction of that. A medical liability provider in the state, operated by the Cooperative of American Physicians, quotes $16,240 for obstetrician/gynecologists for a region of counties that includes San Francisco. States with the lowest rates all had a common denominator — reasonable limits on non-economic damages. For internists in California, Idaho, Mississippi, North Dakota, South Dakota, and Texas, comprehensive coverage was available for less than $5,000 per year. Lower liability costs for physicians translate into more affordable and accessible care for patients.
The Bronx County Medical Society
Sunday, October 12, 2014 we held our 100th year Gala Membership Assembly/Expo, Auction & Dinner Dance at the New York Botanical Garden. We honored of our immediate past President Louis C. Rose, MD. We also published our annual Souvenir Journal in recognition of our past president. Many thanks to the following organizations, each of which was presented with a recognition award
Visit www.bronxdocs.org to view the journal and photographs

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We Honored Immediate Past President 2013-2014
Louis C. Rose, MD

Richard Izquierdo, MD was honored as well
Recipient of the 2014 Distinguished Service Award

Gala Chairs, Dr. Alan Diaz
& Dr. Realba Rodriguez

Andrew Kleinman, MD President of MSSNY & Our Medical
Students from Albert Einstein College of Medicine

Dr. Gurkan F. Taviloglu & Dr. Louis C. Rose

Richard Izquierdo is presented the
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