



BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY
DECEMBER, 2010



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THE BULLETIN

The Oklahoma County Medical Society

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About the Cover

The photograph of downtown Oklahoma City is a winter scene titled "A Snowy Galaxy Accents the Sleekness of Leadership Square." We are grateful to Linda Barry for its reproduction. Ms. Barry is a computer programmer for Globe Life Insurance, with a passion for photography. She is a frequent contributor to the "Last Look" pages in the Southwestern Publishing magazines. She had several pictures published in *Spirit of the Buffalo: Oklahoma Past and Future*, an Oklahoma Centennial coffee table book. □

Seasons Greetings
The Editorial Staff

2011 OCMS Inaugural

The New Year will "officially" open on Saturday, January 15, 2011, when OCMS members and guests gather to honor Robert N. Cooke, MD, the Society's 111th President, and his lovely wife and OCMS Alliance past president, Diane. The festive event will be held at the Quail Creek Golf & Country Club. A reception will begin at 6:30 p.m. and dinner will be served at 7:30 p.m. The Wise Guys will entertain with lively music and the dance floor will be open. Invitations will likely arrive in your home mail box during the holiday onslaught of catalogs and other mail so watch closely for it and return your reservation card quickly. □

In Memoriam

Souther Fulton Tompkins, MD

1916 - 2010

Galen Robbins

1928 - 2010

Who's a Dinosaur?

Philip Maguire, MD

A recent article in Forbes magazine, "Herding Dinosaurs," described the difficulty in bringing some "older" physicians into the age of modern technology: *computers*. Those of us who sat with patients and discussed their ailments seem reluctant to (any) change, particularly the idea of filling the blanks on a computer screen while trying to listen to the patient and still have them believe you really are concerned about them.

That's not to say these physicians don't understand such things as USB, URL, Jpeg and shell macros, or merge codes, scanners and back-up requirements. They also will need to understand the acronyms HIT, EMR, EHR, PHR, HIE, RHIO and more. They must worry whether their data base platform is compatible with the hospital's. It's just that they have gotten along all these years talking to patients and giving comforting nods to the patient's answers while looking directly at them – without the need to look down and check a box on the computer screen.

Get ready, my friends – the change is here and now! You will need to go to several classes and study the methods on how to admit someone to the hospital – to each hospital, how to order medications and how to order and receive laboratory work, as well as how to discharge patients.

But just think: When you are finished, your chart will be complete and you will not need to go to the Record Room or have the staff there pester and threaten you about incomplete charts. I think. □



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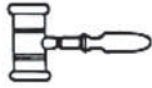
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President's Page



Larry A. Bookman, MD



Farewell

The time has come for my last President's page. The past year has been busy and has passed very quickly. I have tried to use this space to educate, inform and sometimes humor you, the reader. I hope I have accomplished at least one of these goals and that you have enjoyed reading the past pages. Now it is time to be nostalgic and give thanks to all those who really do the work.

I am proud of the work done this year by the OCMS board. I truly feel I have had the best board of directors any president could desire. I won't name them individually, but I thank each of them for their support and energy. I think we have accomplished a successful year. We had an interesting and informative "debate" between our gubernatorial candidates at our last general meeting and had the first meeting of our new Leadership Academy on November 13. The first board retreat in several years was organized to continue our goal of becoming more relevant in a new generation of health care. And in partnership with OSMA, we have continued our efforts to increase our membership rolls and encourage an active participation of all members. "Deunification" from the AMA has allowed our members to choose whether they want to be members of the national organization or use their energy and time improving medicine on the local landscape alone. This was debated for many years and finally accomplished this past year.

In the year to come, OCMS members will continue to push for additional changes in tort reform, worker's comp and especially funding by the state of the indemnity fund passed in the last legislative session. OCMS will continue to support the important work done by the Health Alliance for the Uninsured, the Open

INTEGRIS Health

BRINGING COMPASSION HOME



INTEGRIS EXPERTISE EXPANDS AGAIN

INTEGRIS Health has acquired Odyssey HealthCare of Oklahoma City, which includes hospice home care and inpatient services. Hospice of Oklahoma County, Inc. (an affiliate of INTEGRIS Health) will provide the services previously offered by Odyssey HealthCare of Oklahoma City in an effort to strengthen services.

The inpatient facility opened in 2006 and is located in northwest Oklahoma City. Caring for approximately 800 patients, the twelve-bed facility will be known as INTEGRIS Hospice House. This is Oklahoma's first licensed inpatient hospice facility, and the newest addition to INTEGRIS Health.

We are excited about the new addition to our family of healthcare services — and look forward to caring for more Oklahoma families by bringing compassion home. Hospice of Oklahoma County is certified by Medicare, and is one of an elite group to be accredited by The Joint Commission.

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Arms clinic, and the OCMS Alliance, and will continue its efforts to improve the health of all those within our borders.

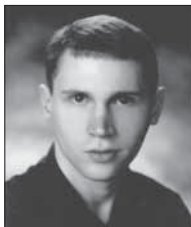
None of this would be possible without the tireless and incredible efforts of the OCMS staff. Jana Timberlake, Linda Larason and Ashley Merritt do the work of dozens and make the president look good. I must also say thanks to our retired, long-time employee Debbie Adams Thomas, who has returned temporarily while Ashley welcomes her new arrival, Reed. I truly bow to each of you and thank you for your support and hard work in bringing each of the OCMS activities to fruition. Those on the board and in executive positions know the wheel would not turn if not for your efforts.

I also want to thank Barbara Ragsdale, my medical assistant and right hand person. If not for her efforts, my life would have been chaos between OCMS business and meetings and an active GI practice.

I would be remiss to forget my supportive wife, Kathy, who has spent many nights waiting dinner, attending affairs, listening to my frustrations and critiquing my President's Pages as they were developed. The tables will be turned in 2011, as she becomes the president of the OCMS Alliance and I serve as "first husband."

So, as I say goodbye, I wish each of you a very Merry Christmas, Happy Holiday and healthy New Year. I encourage each of you to support Dr. Bob Cooke, your new president, and become active in your local medical society. Our voice truly is loudest when all are included. □

New Members



Ian D. Bond
(AN)
1111 N. Lee
Louisiana State University,
Shreveport, 2003



Allen R. Malloy, MD
(R)
700 NE 13th St.
University of Oklahoma
2001



Thank You!!!

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We wish you the merriest of holiday seasons

James W. Hampton, MD, Editor-in-Chief
Linda Larason, Managing Editor



Dean's Page

M. DEWAYNE ANDREWS, MD

Executive Dean

University of Oklahoma College of Medicine

Accreditation of the College of Medicine's medical education program is critical to all our missions and has implications for many programs within the overall governance of the College. During January 2011, the Liaison Committee on Medical Education (LCME) will conduct a full accreditation site visit at the College of Medicine. The U.S. Department of Education delegates to the LCME the responsibility and authority for accreditation of medical education programs in the United States. The LCME comprises a seventeen member national committee sponsored by the Association of American Colleges and the American Medical Association with Secretariat offices in Washington DC (AAMC) and Chicago (AMA). The LCME conducts its full accreditation reviews on all medical schools approximately every seven to eight years, with interim reports required from some schools between scheduled full accreditation cycles. Medical schools must be in compliance with over 120 specific *standards* to receive and maintain full accreditation of their medical education programs.

Preparations for our January 2011 accreditation site visit began in July 2009, and involved the formation of a coordinating task force and designated committees under the overall direction of Chris Candler, MD, Associate Dean for Academic Affairs, and Jon Brightbill, Assistant Dean for Administration. The committees were charged to conduct an in depth "institutional self-study" over a 12-15 month period. Major areas covered in the self-study include: institutional setting and governance, the educational program leading to the MD degree, medical students, faculty, and educational resources. This self-study is instrumental in gathering information to identify our strengths as well as opportunities for improvement and is a major factor in the preparation for

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the accreditation visit. Approximately 150 faculty and students participated directly as committee members with many more participating indirectly in the information gathering. Students conducted an independent survey and analysis which was of excellent quality and is included in the documents provided to the LCME. The self-study task force collated all the information, an executive group prepared narratives and a summary of the self-study, and all required documents (including the exhaustive database) were delivered for review to the LCME site visit team in October 2010. This package totaled 1,260 pages of narratives and documentation. A six-member team, including deans from other medical schools, with extensive experience in medical education and medical school standards will conduct the site visit. During the five day visit (four in Oklahoma City and one in Tulsa), the LCME team will meet with approximately 120 individuals as they rigorously examine each area of our medical school. The final outcome of the accreditation visit will not be known until the full LCME acts on the report and findings, which should be in the spring of 2011. We are encouraged by the outcome of the self-study and the knowledge that the College of Medicine did well for its last accreditation cycle in 2003. I'll keep you posted on the results.

Lastly, may I take this opportunity on behalf of the College of Medicine to extend our best wishes for a wonderful holiday season and happy New Year to our many friends and colleagues in the Oklahoma County Medical Society. □

Will We Never Learn?

ABC News reported on October 1 that a recent study revealed nearly 40 percent of calories consumed by kids ages 2 to 18 are empty calories. Half of those calories are from soda; sugary fruit drinks; grain desserts, such as cake, cookies and donuts; dairy desserts such as ice cream; pizza; whole milk, which is far fatter than skim. The study was done by researchers at the National Cancer Institute in Bethesda, MD, which analyzed data from the National Health and Nutrition Examination Survey.

Nonetheless, Halloween candy sales were on a trajectory to surpass 2009 sales by 7 percent, according to a CNN report on October 20. □

Congratulations!!!

James W. Hampton, MD, long-time Editor-in-Chief of the *Bulletin*, was recently honored by the Mayo Clinic Spirit of EAGLES director Judith S. Kaur, MD who had initiated the Hampton Faculty Fellow Program. Dr. Hampton was the first Native American Medical Oncologist. The Program will train qualified junior faculty health disparity researchers in cancer prevention and control and promote their career development as competitive health disparities researchers. Spirit of EAGLES at the Mayo Clinic Comprehensive Cancer Center in Rochester, MN will partner with the Native American Research and Training Center at the University of Arizona, the Northwest Portland Area Indian Health Board and Oregon Health and Science University, the University of Washington, Clinical and Translational Science Institutes (CTSI) at the Hutchinson Cancer Center in Seattle and the University of Wisconsin in Madison. The Program will mentor 8 – 10 Native American junior faculty researchers; train Fellows in community based participatory research, project management, evaluation, grant development and writing, and health disparities; use experiential learning; fund attendance and presentations at trainings and conferences; disseminate research data to Tribes and present results at research conferences; and publish articles for peer review. Spirit of EAGLES previously established the Hampton Scholars program in 2001. □



Drs. Hampton (Chickasaw-Choctaw) and Kaur (Choctaw-Cherokee) are the only two Native American Medical Oncologists. Dr. Hampton was honored in Seattle, WA by the Spirit of EAGLES of the Mayo Clinic College of Medicine. Dr. Kaur is Professor of Oncology, College of Medicine, Mayo Clinic.

Director's

DIALOGUE

THE CIRCLE OF LIFE

*When you were born, you cried and the world rejoiced.
Live your life so that when you die, the world cries and you rejoice.*

White Elk

There is nothing more beautiful than a mother cradling her newborn child. When I first saw Reed Connelly Merritt, he was content hearing his mother's heart beat as he slept ever so soundly with her arms wrapped safely around him. Reed's parents, Ashley (OCMS Membership Coordinator) and J. Robert, were in that cloud of surrealism that new parents experience upon the birth of their first child ... when they couldn't believe he was actually theirs. Born on October 24, 2010, at 5:18 p.m., Reed weighed 8.6 pounds and measured 20 inches long. Ashley recounted how loudly he screamed and cried after he was born but ceased his tears immediately when he was placed on her chest. That is when I began looking for a handkerchief! And, the circle of life had begun.

A few days later, I attended an Appreciation Tea for the INTEGRIS Baptist Medical Center Volunteer Auxiliary to recognize the Auxiliary's significant contribution applied toward the purchase of the INTEGRIS Hospice House. Terry Gonsulin, RN, Executive Director, INTEGRIS Hospice of Oklahoma County, stated, "We are fulfilling a dream by having an inpatient unit ... and want to recognize the INTEGRIS Baptist Medical Center Auxiliary who made this possible by their generous donation." Hospice House is a special place for the dying patient where the emotional, social and spiritual impact of dying involves both the patient's family and friends in a home-like setting. Thus, the circle of life ends.

In the span of a few days, I thought of the dichotomy of life and death ... and the life experiences in between that contribute to the character of an individual. People rejoice upon hearing the first cries of a newborn child. At life's end, friends and loved ones are

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saddened to lose someone who was a vital, special part of their lives. Thus, the definition of the circle of life played before my eyes.

Organizations also have a circle of life. Each year brings a new President and Board of Directors. As this year slowly winds to a close, the staff wants to thank Dr. Larry Bookman for his contributions to the Society. Dr. Bookman *is* the definition of a good leader. I believe his greatest strength is the ability to quickly assess a situation and determine the best course of action. The OCMS staff and I thank him for his accessibility and good counsel during the year. We also are appreciative of the Society's other volunteer leaders – the 2010 Board of Directors – for their contributions of both time and wisdom. And, we would be remiss if the 2010 OCMS members were not recognized for their loyalty to the organization. Without all of you, the Society would not exist.

Linda Larason and Ashley Merritt are hard-working, dedicated staff members who make my job look easy. I admire them for their skills and work ethic but also cherish them as friends. They're the best! And, a big thank you to the Health Alliance for the Uninsured staff, Pam Cross and Joe Denney. They offer assistance when needed, and I do not know how we ever existed without Joe's computer expertise. He probably hears "Joe, I need help" in his sleep!

As the holiday season nears, remember that the season is not about the gifts we receive but about those we give to others ...

*The joy of brightening other lives,
bearing each other's burdens,
easing each other's loads and
supplanting empty hearts and lives with generous gifts
becomes for us the magic of Christmas.*

W. C. Jones

Happy Holidays! □

Jana Timberlake, CAE, Executive Director



On Professionalism

Honoring Patient's Right to Refuse Medical Treatment

S. Sandy Sanbar, MD, PhD, JD, and Chris Coddling, MD

Modern medical professionalism generally requires honoring patients' informed decisions and advance medical directives regarding medical treatment, including decisions to refuse life-sustaining care, even when patients no longer have the capacity to communicate those decisions to their physicians. Indeed, advance directives were developed for the purpose of preserving a patient's autonomy regarding medical care in the event of incapacity.

Therefore, it behooves medical professionals to:

- Encourage and persuade patients to prepare for incapacity by making their wishes known;
- Regard and honor, and not ignore, the patient's expressed choice to refuse life-sustaining treatment, thereby avoiding keeping the patient alive against his or her will; and
- Refrain from allowing their personal choices and beliefs to influence their decisions.

The role of the medical professional is to fully inform, to advise and recommend a medical course of action but not interfere, either intentionally or negligently, with an individual's right to accept or refuse medical treatment. Health care professionals should be particularly mindful of:

- Withholding or withdrawing life support;
- Provision of unwanted life-prolonging treatment;
- Requested but not provided life-sustaining treatment;
- Inadequate advice to patient about end-of-life issues;
- Improperly obtained consent for an organ donation; and
- Insufficiently worded advance directives if obtained by the medical facility.

It is medically unethical and unprofessional to disregard the patient's express wishes. In the case where unwanted life-prolonging treatment is provided, the medical professional may confront appropriate licensing sanctions by the state medical board. In addition, physicians and hospitals that either

knowingly or negligently provide treatment to the patient despite the presence of advance directives may be subjected to liability lawsuits.

When a medical provider fails to comply with a patient's advanced directive by providing unwanted treatment, the patient, or representative, may bring a civil action for damages under a variety of theories of recovery, including intentional assault and battery, medical negligence or wrongful life. The following are three examples that reached the appellate courts:

1. Patient Winter had chest pains and indicated that he wanted a do-not-resuscitate order to be on file. Despite that, a nurse at the Hospital revived him. Two days later he suffered a paralyzing stroke. Here the patient clearly delimited the medical measure he was willing to undergo, and the health care provider disregarded such instruction. The consequences for that breach would include the damages arising from any battery inflicted on the patient, as well as appropriate licensing sanctions against the medical professionals.
2. The family of Brenda Young, acting as Miss Young's proxy, repeatedly told physicians that her daughter did not want life support. When the proxy requested that the life support be removed, the request went unheeded. Miss Young's estate was awarded substantial damages.
3. A Geriatric Center kept a resident alive and on life support for six days of what her family described as unnecessary suffering, in violation of her living will. The jury found that the nursing home had failed to develop a plan for dealing with the patient's decline in the face of her advanced directives.

In conclusion, medical professionalism entails respecting and following the patient's express wishes, protecting patient autonomy and the concomitant right to refuse medical care. Failure to do so may be construed as a deviation from acceptable ethical, professional and legal conduct, and may result in licensing sanctions and/or lawsuits. □



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Implementing Health Care Reform Why Medicare Matters

Robert A. Berenson, M.D.

Despite the major achievements of the Patient Protection and Affordable Care Act in providing health insurance for more than 30 million Americans and regulating objectionable insurance-company practices, its opponents alleged throughout the health care reform debate that it would negatively affect Medicare beneficiaries. Although nothing in the law (now being referred to simply as the Affordable Care Act, or ACA) grants government the authority to ration care for these patients — to “pull the plug on Granny,” as Senator Charles Grassley (R-IA) put it — Medicare is in fact central to the legislation. Indeed, more than half of the \$938 billion price tag mostly for expanding coverage for low-income individuals will be paid from decreased Medicare spending,¹ which will also extend the solvency of the Medicare Part A trust fund by 12 years, to 2029.²

A new Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) will develop, test, and implement new payment approaches supporting innovations in the organization of health care delivery, such as medical homes and accountable care organizations, to help contain Medicare and Medicaid spending and to serve as models for commercial insurers. But the currently projected savings come from two main sources: reduced payments to private Medicare Advantage plans and reduced payment updates for hospitals and most other providers. A phased elimination of the substantial overpayments to Medicare Advantage plans, which now enroll nearly 25 percent of Medicare beneficiaries, will produce an estimated \$132 billion in savings over 10 years. Since health plans have used the extra payments to enhance benefits packages and entice beneficiaries to leave traditional Medicare, the reductions will not be painless; payment cuts in the Balanced Budget Act of 1997 led to health plans’ withdrawing from Medicare and benefit cuts that made plan offerings less attractive, which together resulted in a 25 percent reduction in private-plan enrollment. CMS Chief Actuary Richard Foster projects that the ACA cuts will cause a decline in Medicare Advantage enrollment of one third by

2017.² The Medicare Payment Advisory Commission (MedPAC) has been calling for such fee reductions for years,³ to keep Medicare Advantage from undermining traditional Medicare.

The ACA also produces nearly \$200 billion in savings by assuming that providers can improve their productivity as firms in other industries have done. On the basis of this presumed improvement, the law reduces Medicare's annual "market basket" updates for most types of providers — a provision that has generated controversy. Foster believes that many providers will not be able to improve their productivity to the required degree and questions whether the payment reductions will stick after providers plead their cases to Congress.² On the other hand, there is evidence that hospitals and physicians facing reduced Medicare payments can shift costs to commercial payers — a strategy that could negate the law's potential for reducing health care spending and increase scrutiny of Medicare as a poor payer because of the growing differential between Medicare and commercial-insurance payment rates.

During the reform debate, opponents of a Medicare-like public option frequently asserted that Medicare is a poor payer, covering only 80 percent of physicians' practice costs. But that argument assumes that generous physician incomes are "practice costs." A recent simulation of physician compensation showed that if all payers used the Medicare fee schedule, physicians would earn an average of \$240,000, with cardiologists earning \$450,000, and radiologists \$390,000.⁴ These compensation levels are poor only in comparison to what some physicians can get from commercial payers and directly from patients (current actual compensation for these physicians is \$273,000, \$483,000, and \$488,000, respectively); the problem lies with providers' growing market power over the prices negotiated with commercial insurers. This problem suggests that we ought to consider setting all-payer rates for providers, but the country's antigovernment mood renders such a discussion unlikely, at least for now. Meanwhile, Medicare beneficiaries could experience problems obtaining important physician services, as physicians seek the greener pastures of the privately insured, turning away Medicare patients as they do Medicaid patients.

Concern that Congress seems incapable of making tough decisions to reduce Medicare spending inspired an extensive

debate about creating a “super-MedPAC” — an independent panel with the authority to reduce Medicare spending. The ACA produced a compromise — the Independent Payment Advisory Board (IPAB) — which will start making recommendations in 2014. Initially, in any year in which the increase in Medicare’s per capita spending rate exceeds the average of the growth in the Consumer Price Index (CPI) and that of the medical care CPI, the IPAB would be required to recommend spending reductions for Medicare. These recommendations would become law unless Congress passed an alternative proposal achieving the same savings.

The board’s role is carefully circumscribed, however. Its jurisdiction is limited to payment — it is expressly prohibited from recommending increasing revenues; changing benefits, including patient cost sharing; or altering program eligibility. Furthermore, hospitals, the largest recipient of Medicare payments, are exempt from IPAB oversight until 2020. In short, the IPAB is not actually allowed to be a super-MedPAC, but its shackles might be loosened if Congress cannot address the mounting fiscal threat posed by unchecked growth of federal entitlement programs.

On another track, the suggestion that as much as 30 percent of Medicare spending is wasted figured prominently in the reform debate. Legislators from lower-spending U.S. regions invoked Dartmouth Atlas research on geographic variation in arguing that current payments are unfair because apparently inefficient providers receive more money than efficient ones. They sought payment penalties for high-spending areas and increases for low-spending areas. Representatives from high-spending areas objected, citing information suggesting that the Dartmouth data are insufficiently adjusted for differences in patients’ underlying health and socioeconomic status and that they ignore needed price adjustments for providing graduate medical education or caring for a disproportionate share of Medicaid and uninsured patients.⁵ Further complicating the policy analysis is the difference between absolute per capita spending and rates of increase in spending: a low-spending geographic area might well have a relatively high rate of increase — which might be reasonable, as it attempts to catch up.⁵ For some policy purposes, the base spending differences might be relevant, but for purposes of bending the curve, rates of spending growth are probably more important.



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The legislation does not settle this issue but seeks further analysis to help formulate policies to reward providers for value. In addition, Secretary of Health and Human Services Kathleen Sebelius is commissioning the Institute of Medicine to study geographic variation and to recommend ways to incorporate quality and value metrics into the Medicare reimbursement system.

From yet another quarter have come complaints that current payment methods penalize efficient providers for offering high-value care and that more pilots and demonstrations, administered by the new CMS innovation center, represent unaffordable temporizing. In particular, some of the multispecialty group practices that have been held up as prototypes of the organizations that new payment models should encourage, including Mayo Clinic and Cleveland Clinic, have expressed frustration with the current volume-based payment approaches for hospitals and physicians. Although some consider the volume-generating incentives of current payment systems so perverse that they would not spend much time correcting existing mispriced values, these payment systems will probably be with us for some time. Moreover, some of the new payment approaches being promoted — for example, bundled payment for an episode of care — will probably build on the current prices. And it is unlikely that highly compensated physician specialties that are thriving under the fee-for-service system will voluntarily participate in the envisioned accountable care organizations that require multispecialty cooperation. Paradoxically, it will be necessary to correct mispricing and other flaws in existing fee-for-service payment systems in order to ultimately dismantle them.

Finally, there was hope that Congress would end the saga of the sustainable growth rate (SGR), the formula used to calculate Medicare's physician-fee updates, which has been consistently overridden and should now produce immediate 21 percent fee cuts to physicians, another 6 percent next January, and a few percent more after that. The House initially attempted to settle the SGR problem by taking all the past fictional savings off the budget books, but since a real fix would have added more than \$200 billion to the cost of reform, the provision disappeared when President Obama limited the legislation's cost to \$1 trillion. The

SGR can continues to be kicked down the road. It seems that the more things change, the more they stay the same. □

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Dr. Berenson is vice-chair of the Medicare Payment Advisory Commission (MedPAC); the views expressed in this article represent his personal views and not necessarily those of MedPAC.

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Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

Source Information

From the Urban Institute, Washington, DC.

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LAW AND MEDICINE

HITECH ACT: Changes in HIPAA Law in 2010

Compiled by S. Sandy Sanbar, MD, PhD, JD, FCLM

Physicians and other health care providers who utilize electronic health record systems will have to comply with updated HIPAA privacy and security rules as early as next year under a proposed rule published by the Health and Human Services (HHS) Office for Civil Rights on July 14, 2010.¹ The rule implements the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH Act) provisions aimed at creating a secure foundation for sharing electronic Protected Health Information (PHI) in the emerging landscape of health care reform. The HITECH Act strengthened and expanded the scope of the HIPAA Privacy and Security Rules, enhanced the HIPAA penalty provisions, provided for HIPAA enforcement by state attorneys general, and established a federal data breach notification law. The heightened safeguards and compliance requirements along with increased penalties for non-compliance pose significant hurdles not only for existing *covered entities* but also for a significant number of additional organizations in the health care industry. The HIPAA privacy, security and enforcement law changes involve *covered entities* (physicians and hospitals) and their *business associates* both of whom must comply with the language of the HITECH Act.² The changes include the following:

1. ***Access to Electronic Health Records.*** Covered entities that use electronic health records must provide patients with a copy upon request; they can charge a reasonable fee for complying with the request, such as copy/labor costs.
2. ***Minimum necessary rule.*** Covered entities are now required to use or disclose only the *minimum necessary* amount of Protected Health Information (PHI) required to complete a covered function, i.e. use a “limited data set” or the least amount of PHI necessary to accomplish the intended purpose.

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3. ***Business Associate Agreements.*** Previously, business associates were required to comply with HIPAA-related privacy laws through a contract with a covered entity, but were not directly responsible for HIPAA compliance. Now, business associates are bound by the HIPAA laws, and must have policies and procedures documenting the same. Specifically, they must amend their business associate agreements to add language that the business associate must comply with the HIPAA rules (including breach notification requirements) and include details on how the business associate will store and safeguard PHI.
4. ***Request for restrictions.*** Covered entities must allow individuals to request restrictions on how their PHI may be disclosed, but are not required to honor such requests. For example, a patient who pays out-of-pocket can request that his health care provider not disclose information about his medical condition or treatment to his employer/insurer. Under the old privacy laws, a covered entity was required to accept the patient's request but did not have to act upon it. Effective 2010, however, covered entities must honor requests not to disclose PHI (for purposes of payment or health care operations only) if the patient pays the entire cost of treatment out-of-pocket.
5. ***Marketing/fundraising communications.*** Currently, covered entities may not engage in marketing activities that use a patient's PHI without authorization. However, an exception exists whereby covered entities and their business associates can encourage patients to purchase or use a healthcare-related product or services without authorization. For example, a cardiologist can send materials to his patients encouraging them to use a certain cholesterol-reducing drug. This exception applies even if the covered entity is paid by a third party (i.e. the drug manufacturer) to engage in such marketing. Under HITECH, such activities are still permitted, but with additional limitations. Specifically, the marketing communications must:


- a. Describe a health care-related product or service that is provided by or included in the plan of benefits of the covered entity making the communication (i.e., an insurance company cannot market a drug that is not covered);
- b. Relate to the treatment of the individual, and
- c. Relate either to the case management or care coordination for the individual or to the recommendation of alternate treatments or providers.

Additionally, covered entities can continue to receive payments in exchange for these communications, but the communications must relate to a drug that the patient is currently prescribed and the payment must be reasonable.

¹ <http://edocket.access.gpo.gov/2010/pdf/2010-16718.pdf>


² http://www.thefederalregister.com/b.p/department/DEPARTMENT_OF_HEALTH_AND_HUMAN_SERVICES/



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Donna Parker

Fulfillment of our mission is the driving force of our rich 85-year history. This year, I am proud to support our members' strong desire to maintain our organization's relevance in a rapidly changing environment.

Our board is taking some extra time this year to question everything about our operations, because we never want to stop trying to improve things. As reported in an earlier Bulletin update, our Governance Committee is hard at work revising and updating our Bylaws. Last May, Frank Merrick of Foundation Management led our joint boards in a review of our mission, vision and focus. A committee of wordsmiths has now updated and refreshed the wording of our mission statement. It is listed in its entirety at the end of this article.

What is on the horizon for the Alliance? Leadership and stewardship directed to make us grow into a more fluid, organic organization that is flourishing with ideas and adaptive - a learning organization in every way possible. Offering members proactive training that is goal-oriented, providing opportunities to brainstorm with others in small groups for more effective communication, and creating Action Plans in each area of our operations that are clearly focused on goals. Organizing impactful meetings that have clear purpose and an opportunity for enjoyment while we concentrate on mission fulfillment.

The Alliance continues to embrace diversity, and we send the clear message to all new members that their input and involvement are valued and encouraged.

If you believe, as I do, that the mission of the Alliance is a lifetime mission, then there is no better time to join us than right now! Because the Alliance provides you a lifetime of membership opportunities, from medical school and residency years through the busiest years of medical practice, well into the retirement years. No other organization can provide you as a physician or physician family member with such a uniquely rewarding network of peers.

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We have shared life experiences, and we respect and honor each other's contributions as fellow members of this very special team.

If you have not joined the Alliance yet, but would like to check us out, go to our Website, ocmsalliance.org, and click on "About Us" or better yet, "How to Join." Please contact us with any questions you may have. Take the first step to becoming involved with your local family of medicine today. □

OCMS Alliance Mission Statement

The Oklahoma County Medical Society Alliance is a non-profit organization of physicians' spouses and physicians who are dedicated to:

- *enriching our community through awareness and education about health and wellness*
- *assisting other non-profit organizations that meet a health-related need within Oklahoma County*
- *partnering with physicians to advocate positive legislative changes on behalf of the medical profession*
- *building a dynamic network for communication and support among our local community of physician families.*

Donna Parker



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	Oct'10	Oct'09	Sept'10	Oct'10	Oct'09
Campylobacter infection	9	5	4	65	80
Cryptosporidiosis	2	1	4	20	12
E. coli 0157:H7	5	1	3	15	8
Ehrlichiosis	0	0	0	1	7
Giardiasis	2	4	0	14	39
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	0	0	3	21	13
Hepatitis A	0	0	0	3	4
Hepatitis B*	13	11	16	155	148
Hepatitis C *	14	11	22	179	220
Lyme disease	0	0	0	10	5
Malaria	0	0	0	1	0
Measles	0	0	0	0	0
Mumps	0	0	0	0	2
Neisseria Meningitis	0	1	0	2	3
Pertussis	4	0	5	36	18
Pneumococcal infection Invasive	1	1	1	11	13
Rocky Mtn. Spotted Fever (RMSF)	8	0	8	33	28
Salmonellosis	15	4	22	119	98
Shigellosis	4	10	4	62	139
Tuberculosis ATS Class II (+PPD only)	41	57	57	526	711
Tuberculosis ATS Class III (new active cases)	2	1	3	22	13
Tularemia	0	1	0	2	0
Typhoid fever	0	0	0	1	2
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	0	4
Pediatric Influenza Death	0	2	0	0	3
Influenza, Hospitalization or Death	0	163	0	13	214
Influenza, Novel Virus	0	15	0	0	65
Strep A Invasive	1	2	1	21	33
Legionella	1	1	1	5	3
Rubella	1	0	0	3	0
Listeriosis	0	0	0	1	2
Yersinia	0	0	0	1	0
Dengue fever	0	0	0	1	0

* - *Over reported* (includes acute and chronic)

[^] *YTD - Year To Date Totals*

STDs/HIV - *Not available from the OSDH, HIV/STD Division*

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Contact: Yvonne Curtright
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Telephone: 604-4979

Deaconess Hospital Tuesday CME Program

Contact: Denise Menefee
Medical Library
Telephone: 604-4524

Integris Baptist Medical Center

Contact: Marilyn Fick
Medical Education
Office
Telephone: 949-3284

Integris Southwest Medical Center

Contact: Marilyn Fick
CME Coordinator
Telephone: 949-3284

Mercy Health Center

Contact: Debbie Stanila
CME Coordinator
Telephone: 752-3806

Midwest Regional Medical Center

Contact: Carolyn Hill
Medical Staff Services
Coordinator
Telephone: 610-8011

Oklahoma Academy of Family Physicians Choice CME Program

Contact: Sue Hinrichs
Director of
Communications
Telephone: 842-0484
E-Mail: hinrichs@okaftp.org
Website: www.okaftp.org

OUHSC-Irwin H. Brown Office of Continuing Medical Education

Contact: Letricia Harris or
Kathleen Shumate
Telephone: 271-2350
Check the homepage for the latest
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St. Anthony Hospital

Contact: Lisa Hutts
CME Coordinator
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Orthopaedic & Reconstruction Research Foundation

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