BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

MARCH 2013

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The Oklahoma County Medical Society

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About the Cover

Dr. John Salmeron has been growing beautiful orchids for 40 years. Orchids can be found all over the world except Antarctica and were on the earth with the dinosaurs. There are 30,000 orchid species on the planet; Dr. Salmeron grows 15 of those in his custom-designed greenhouse. Read about Dr. Salmeron and his orchids starting on page 21. ❑

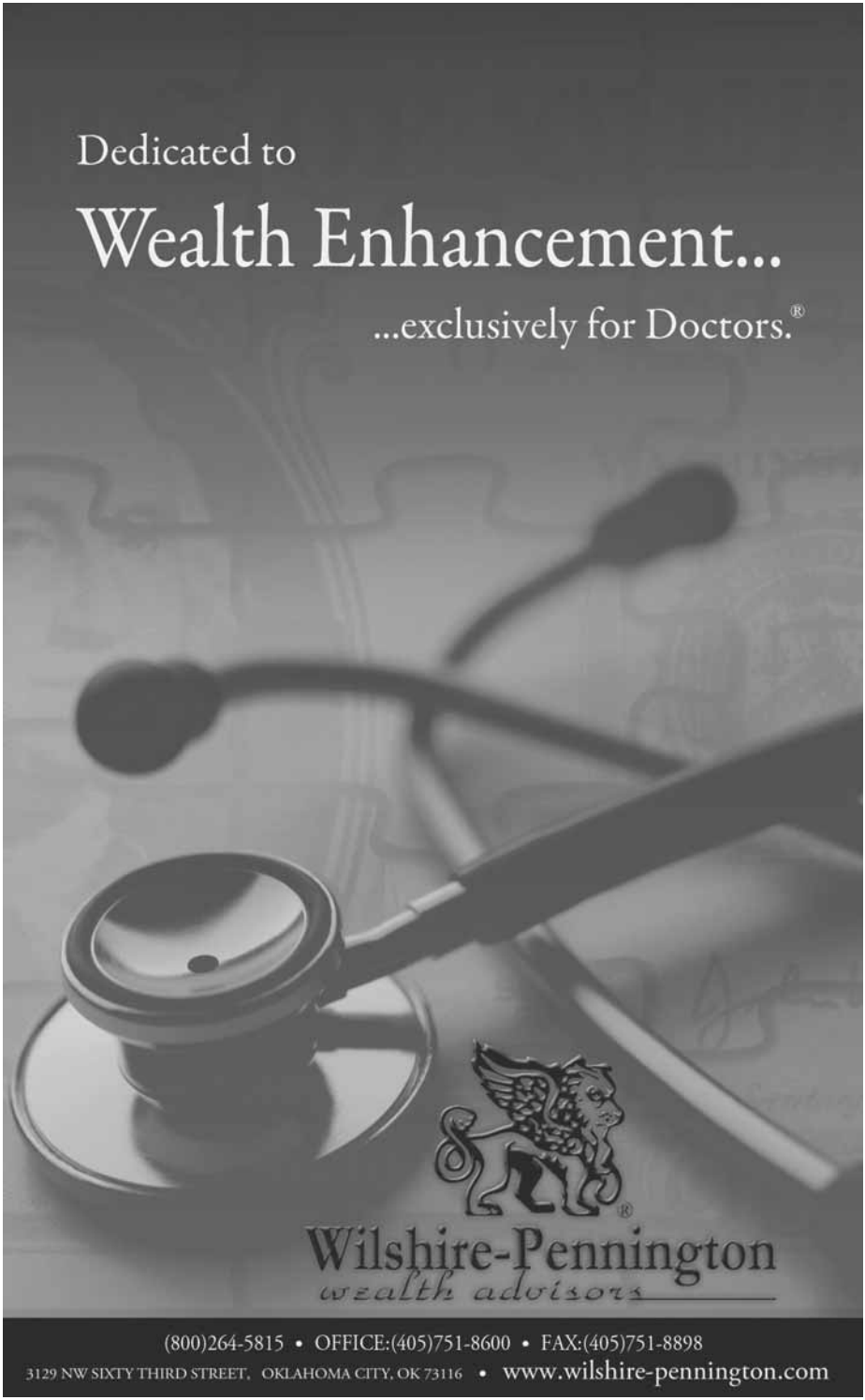
2013 OCMS Caucus / OSMA Annual Meeting

Oklahoma County's OSMA Delegates Caucus will be Thursday, March 7, 2013, from 5:30-6:30 pm in the OSMA Board Room. (This date was changed from the original date of March 14.)

The purpose of the meeting is to discuss items that will be on the agenda at the OSMA House of Delegates (HOD) Annual Meeting, which will be Saturday, April 20, 2013, in Oklahoma City.

Resolutions must be submitted to OSMA by March 21 to automatically be referred to the HOD. If you plan to submit a resolution for consideration by our caucus, please fax it to 702-0501or (preferably) email it to tsenat@o-c-m-s.org. Any received by OSMA between March 22 and April 12 will require a simple majority of the OSMA Board of Trustees to be considered by Delegates at the HOD. Any received between April 13 and April 20 will require a simple majority vote of the HOD to be considered.

We hope to see you there! ❑



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President's Page

Thomas H. Flesher III, MD

Good Deeds

As I write this column, we have just entered the new year. We seem to have survived the end of the current cycle of the Mayan calendar. Most of us did not fall off the Fiscal Cliff, although we witnessed almost unbelievable political antics. ObamaCare is becoming a reality, although few of us really know all of the details of how it will affect physicians.

Locally, our Oklahoma Legislature is poised to convene, with all the accompanying rhetoric about new changes and how much they intend to change our great State for the betterment of all our citizens. The Oklahoma County Medical Society is also starting the new year with new officers and board members striving to match the leadership of past years.

Each individual physician in the county is also working to provide good medical care to patients. Every day, physicians do something good for someone else: a good deed. Each of us gives advice or performs services without compensation for the good of individuals or organizations, with no expectation of anything in return. We do these good deeds for the benefit of others. Many non-physicians cannot understand this, but for us it is a way of life and part of the privilege of being doctors.

At the Oklahoma County Medical Society, we also do good deeds. Most recently, we have become involved with the ITN (Independent Transportation Network). It is an organization that provides 'dignified transportation' for senior citizens who should no longer drive, with no restrictions on where they can go. ITN has been successful in other cities and we expect good things in Oklahoma County as well. We look forward to a healthy new year for our Medical Society. ❑

100 Years Ago
at the Oklahoma County Medical Society

Thomas H. Flesher, MD

In 1913, Thomas H. Flesher, MD, a prominent young physician and surgeon from Edmond was named President of the Oklahoma County Medical Society.

In 2013, Thomas H. Flesher III, MD, followed in his grandfather's footsteps and was installed as President of the Oklahoma County Medical Society, exactly 100 years later!

In Memoriam

Abel J. Sands, MD
1920– 2012

Robert Wallace King, MD
1921-2013

Guy W. Fuller, MD
1926-2013

Walter H. Whitcomb, MD
1928-2013

2013 Inaugural Dinner

Dr. Thomas H. Flesher III was installed as the 113th President of the Oklahoma County Medical Society at the annual Inaugural Dinner in January. The Rhinehart Medical Service Award was presented to Dr. Roxie Albrecht, the first and only fully dedicated Trauma Medical Director at OU Medical Center's Level I trauma center.

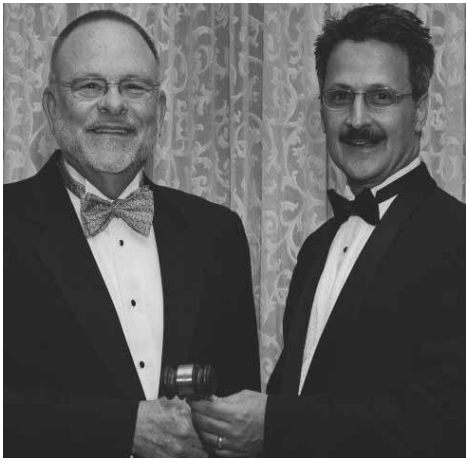
Thomas H. Flesher, III, MD, the 113th President of the Oklahoma County Medical Society

2013 Officers (left to right): Don Wilber, MD, Secretary-Treasurer; Thomas H. Flesher, III, MD, President; Julie Strebel-Hager, MD, President-Elect; and C. Douglas Folger, MD, Vice President.

2013 Inaugural Dinner Photos

Honored at the dinner were Dr. Thomas H. Flesher III, 2013 President; Dr. Julie Strebel-Hager, President-Elect; and Dr. Tomás Owens, Past President.

Emcee and Past President Dr. Robert N. Cooke presents the President's Plaque to outgoing President Dr. Tomás Owens.



Outgoing President Dr. Tomás Owens presents the president's gavel to President Dr. Thomas H. Flesher III.

2013 Inaugural Dinner Photos

Dr. Roxie Albrecht was presented the Don F. Rhinehart Medical Service Award by Outgoing President Dr. Tomás Owens.

Emcee and Past President Dr. Robert Cooke presents a gift to Tammy Owens, wife of the outgoing president.

Linda Larason, who retired from OCMS after almost 10 years of service, receives bound Bulletins from Dr. Tomás Owens.

2013 Inaugural Dinner Photos

2013 Board Members: First row, left to right: Dr. Tomás Owens, Dr. Don Wilber, Dr. Thomas H. Flesher III, Dr. David Holden, Dr. Julie Strebel-Hager, Dr. C. Douglas Folger and Dr. David Teague. Second row, left to right: Dr. Ralph Shadid, Dr. Don Murray, and Dr. J. Samuel Little.

Suzanne Reynolds, 2013 Alliance President, with Joni Flesher and Donna Parker.

Pearl of the Month

Anu Bajaj, MD

Insurance for Breast Reduction

I have noticed that although many physicians understand the benefits of breast reduction surgery for their patients, not all physicians and patients understand the process of obtaining insurance approval for a breast reduction. According to the American Society of Plastic Surgeons, over 60,000 breast reductions were performed for reconstructive purposes in 2011. And most plastic surgeons report that breast reduction patients are some of the most satisfied patients, with some studies reporting a patient satisfaction rate of over 90%.

Despite this high rate of patient satisfaction, many insurance companies are making it increasingly difficult to obtain a breast reduction. One of the main issues is the issue of medical necessity. Breast reduction is also known as a reduction mammoplasty and is used to treat the symptoms of symptomatic macromastia. Macromastia is a term used to describe excessively large breasts; symptomatic macaromastia is the diagnosis for women who experience symptoms related to their large breasts.

Common symptoms experienced by patients with large breasts include neck pain, back pain, inframammary intertrigo, chronic headaches and migraines, shoulder grooving and ulnar nerve paresthesias, difficulty with finding appropriately supportive clothing, and difficulty with certain activities. If a woman is experiencing these symptoms and is considering surgical intervention in the form of a reduction mammoplasty

or breast reduction, there are several steps she should take. First, she should check her insurance policy to determine if a breast reduction is a covered procedure. Under some policies, a breast reduction is a policy exclusion, meaning that the patient will have to pay for the procedure out-of-pocket.

Second, her symptoms and any attempts at non-surgical treatment of her symptoms must be documented. In other words, not only does the patient have to have these symptoms, but she must also go through a trial of non-surgical treatments including pain medication, NSAIDs, a trial of physical therapy or chiropractic therapy, an attempt at weight loss, and trying extra-supportive brassieres. Typically, an insurance policy will specify the length of time required of these non-surgical treatments – they can range anywhere from 3 months to one year. And the failure of these non-surgical treatments has to be documented by the patient's primary care physician. An insurance carrier may deny coverage if there is inadequate documentation of these attempts at non-surgical therapies.

Once the patient has completed a trial of non-surgical management, she can be referred to a plastic surgeon for consideration of operative intervention. Most insurers will require the plastic surgeon to write a letter describing the symptoms, past attempts at non-surgical management, and an estimate of the amount of breast tissue to be removed. Under these circumstances, it is in the patient's and physician's best interest to obtain insurance preauthorization prior to surgery. If it is not appropriately obtained, the insurance company may not be under any obligation to pay for the surgery.

Additionally, during this process, some insurers may require a minimum number of grams of breast tissue to be removed, and this number is usually included in the preauthorization letter from the insurance carrier. The number of grams may be related to a patient's body weight. If the surgeon removes less than the specified minimum mandated by the insurance carrier, the surgeon may not be paid for the procedure. For this reason, I counsel my patient prior to surgery if I believe that I cannot guarantee that I will be able to remove the minimum amount of breast tissue mandated by their insurance company. Typically, when we perform a breast reduction, the goal is to remove enough breast tissue so that the patient's symptoms are alleviated but leave enough behind so that there is an adequate

blood supply to the nipple areola complex and the patient still has an aesthetically shaped breast.

If a patient is denied coverage for a breast reduction and is told by her insurance carrier that the procedure is cosmetic, she can appeal this decision. Similarly, if the patient has unusual circumstances (small frame with large breasts, arthritis, or other medical condition that may be aggravated by large breasts, etc.), she may appeal as well. Unfortunately, in my experience, these appeals are becoming increasingly less successful as more and more insurance companies are trying to control costs. During this process, all of the supporting documentation provided by a primary care physician is extremely important.

Another option for a patient is to consider paying for the procedure herself. Most plastic surgeons do have cosmetic pricing for a breast reduction – which includes surgery, operating room, anesthesia, and pre- and post-operative care. Once all other avenues are exhausted, this is another option if the patient and her physicians believe that she will benefit from a breast reduction.

I hope that by writing this article, I was able to explain the process of having a breast reduction covered by insurance. While many patients have symptomatic macromastia, not all of them have jumped through the appropriate hoops of non-surgical management required by most insurance carriers today. Many of these patients become frustrated by the delay in surgical intervention once they have been referred to a plastic surgeon. By being cognizant of the guidelines set by an insurance carrier, we can better provide the appropriate care for our patients without delaying their surgical treatment if it is necessary. ❑

New Member

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Young Physicians

Chris Carey, MD

Creating A Diamond In Medicine

There has been a great deal of discussion over the last several years regarding the changes in resident training and the hour restrictions being enforced by ACGME.

During my residency, which began in 2004 and ended in 2011, I was fortunate or perhaps unfortunate to see all aspects of these restrictions. The beginning of my intern year was the start of the 80-hour work week and needless to say it was more of a goal than a requirement. However, by the end of my training it was very heavily enforced, as the fear of being penalized for violating the restrictions became a reality.

I can't say I noticed much difference over those seven years but began to wonder if my younger colleagues would have the confidence in their ability to perform any procedure at their graduation day. I am unsure if I know the answer to that question, nor do I really have a great answer for ongoing changes in resident training. However, I do believe having success post-residency relies on finding good mentors to help guide you along the way.

When you look at the history of surgical training, the modern era starts with Halstead. He really changed the structure of surgical residency, mentorship and teaching following medical school.

Certainly, resident training has changed. However, the basic principles still apply. This involves being around experts in your field and forming relationships that will influence and drive you for the rest of your time in practice. Although I have adapted some procedures I do routinely, I still use techniques taught to me by my mentors during residency. These physicians

were invaluable to me. They passed knowledge and skills to their students who will always have a deep appreciation and respect for their guidance. I still look forward to visiting with them at national meetings and call on them for advice in tough situations.

Following residency you begin the next journey of your career. At the end of my seventh year, I was more than ready to finish and truly felt I was very well trained and capable to perform on my own at that point. Yet, there was suddenly an island of uncertainty to make the right decision and what to do when things did not go the way as I had planned or what was clearly outlined in the 5th addition of Mastery of Surgery.

There have been plenty of growing pains and lessons learned on things I would do differently in the future. Unlike residency, as the attending you agonize over unexpected outcomes and complications when you previously only had to present them weekly in morbidity conference. Before, it was the team approach and you felt perhaps not directly responsible. Now, all of sudden, you are the attending. Your name is listed and the family trusts you to make the correct decision. Through discussions with my colleagues, this stress and concern transcends all specialties. As caring physicians, we all worry if we made the right decision, made the correct diagnosis and prescribed the correct treatment. This is how our partners and mentors help guide us.

Transitioning from an academic to a busy private-practice, I certainly had and continue to have a great deal to learn. However, no matter my training or time spent, I would not have been successful without my partners' help and advice along the way. I call them my partners but in truth they are all my mentors.

They were there when I started to ask about how to begin my practice and they are there now to help with difficult cases or just listen when things have not gone well. They recognize when I am down and are there to listen or provide advice when I am stressed about a case or how my patient is doing. As my partner Dr. Jay Cannon always reminds me, "Surgical judgment comes from experience, and experience comes from poor surgical judgment." This is a quote that has been passed on to him from his mentor that remains true today. It is a phrase that always makes me smile and keeps me going.

Perhaps naïve, you think as a new physician you can save or treat anyone. However, there is a humbling effect that results in numerous sleepless nights. Speaking for my surgical colleagues, we all have nights that we stay up concerned about our patient, checking their labs and studies. I know this is not unique to a surgical practice but crosses to all physicians.

To be honest, sometimes the stress and concern can be consuming. There are times during the first year post-residency when you are driving home at 1 a.m. and you are uncertain about your career choice. However the following day, you discuss it with your mentor and they either reassure you or let you know this happened to them last week. Then, you know you can keep going.

As young physicians we are fortunate enough to train in the latest cutting-edge technology. With progress, there is continued stress to ensure you remain current with the ever-changing techniques, guidelines and procedures. Yet, I know how much of a privilege it is to be a part of someone's life in difficult times and would still argue that it is the best profession.

We all have a dramatic impact on people's lives daily. This may be through treatment or simply taking time to sit down and listen to a patient's concerns. However, I know we are not alone. In meeting physicians around Oklahoma, we are surrounded by wonderful people who are great mentors who can provide invaluable guidance.

From my academic mentors who inspired me to my current mentors who keep me going, "Thank you." Don't hesitate to approach them for advice and inquire how they practice. I learn something every day and realize I have a high standard to uphold. Always remember, in our very-respected profession we are always being watched. I know we all want to lead by example and one day we will be valuable mentors as well. As one of my most loved mentors during my training, Dr. John Tarpley, would say, "The only real difference between graphite and diamonds is pressure." I know with the mentorship of my colleagues I can survive the pressure and hope to become a diamond. ❑

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The Defense of Brown

Hanna Saadah, MD

I do not argue when I know I'm right;
I wait and let the truth retaliate
But she was my exception; she said brown was unintelligent
A charmless rust, newspapers' ghost, and newsmen's echo
That was all she saw:
the hollow utterings of creeds and institutes of man
Of lovers, dreams, and promises un-kept;
all that was brown to her.

Madam, I answered; let me redirect your gaze to other scenes:
Have you not been astonished by the flapping browns of fall
Those ardent letters aired by trees in love?
Have you not been intrigued by ancient seas
Who sun their waves and tales upon the sand?
Nor been seduced by beaches giving birth
To naked tans who sweat on dizzy shores?

She posed and I went on:
My garden is a miracle of bloom
A resurrection from the dead brown dirt;
Wheat fields are poems sung by earth to sun;
Your hands are veins of wine and loaves of bread;
Old books defend the fragile roots of time;
Earth, brown to the core, is the only wife of God
Mother to all His children, refuge to the dead;
Life is an aging trip from green to brown.

She said when I was through
Love is a journey too
From red, to blue, to brown.

"Too often we...enjoy the comfort of opinion without the discomfort of thought."
~ John F. Kennedy

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For the Love of Orchids

by Tracy Senat

Dr. John Salmeron started growing orchids because it was interesting. Quickly it became a passion of his and today he has a custom-made greenhouse full of 15 species that he lovingly cares for.

"I can't think of anything else that gives me more pleasure or is more entertaining," he said.

Dr. Salmeron is a retired anesthesiologist who began practice in Oklahoma City in 1963. He was invited to dinner by Dr. Sam Moore, an orthopedic surgeon who had several orchids.

Dr. John Salmeron

"I looked at those orchids and thought I should be able to grow them, too," he said. So he bought a couple and the rest is orchid history.

After a few years of growing orchids, Dr. Salmeron decided he needed more space to care for them properly, so he remodeled part of his house into a 30'x 22' climate-controlled, ventilated greenhouse that controls for humidity, temperature and light.

The proper care of orchids requires an understanding of botany, entomology and geography, among others. Orchids are found all over the world except Antarctica; they were on the earth when dinosaurs existed. There are more than 30,000 species in all.

Today, just watering his approximately 200 orchids takes more than an hour. Each plant must be dry before watering as overwatering is the main killer of orchids. When they are watered, they must be moist all the way through. The amount

of water needed depends on time of year, even in the controlled environment, and the size of the pot.

"The amount of humidity, moisture and light must be controlled and maintained," he said. "And air has to be moving all the time – an orchid can stand anything as long as the air is moving." Orchids can tolerate the high temperatures of the jungle because the air is always moving, so his greenhouse includes 6-8 fans that stay on every day.

The type of pot also is important, as different species have varying needs. Some need to be moist most of the time so they need to be in plastic pots, while those that need to dry thoroughly before watering need ceramic pots. Large plants can't tolerate plastic because it retains moisture.

Each plant in the greenhouse has a label that includes information such as what type of plant it is, when it was potted and when it last bloomed, and the information is updated as needed. The greenhouse has a purifying system that removes impurities from the water through reverse osmosis. It is a constant filtering system that maintains 20-30 gallons of this distilled water.

Orchids need fertilizers for nutrients, but growers must be careful as over-fertilizing is the second leading cause of orchid death. Pots must be sterilized because spores of fungus or viruses can transfer to the next plant put in the pot.

Dr. Salmeron has found a young helper who truly loves orchids and helps him in the greenhouse once a week.

"She understands how to mix the medium in which orchids can grow as they don't grow in regular dirt, how to properly spray for insects, choose the correct pot, and repot a plant," he said. The potting medium must be pressed solidly when planting.

When he has guests over, he brings some of his orchids inside for viewing, then returns them to the greenhouse as the house environment is not healthy for the plants.

Dr. Salmeron also nurses a few orchids for friends, who have asked him to nurture them back to health.

"Orchids are like pets, they are living things," he said. "You don't mistreat pets and throw them out if they're thirsty, not feeling well, or exposed to the cold."

Dr. Salmeron is an active member of the Oklahoma Orchid Society, where he shares his love and knowledge of orchids with others. He used to attend orchid shows frequently, but now mainly attends when he visits family and friends in California and Hawaii.

"When I was practicing full-time, I had no time to care for the orchids," he said. "Then I realized there is only so much time left. If you define yourself with your work, there will come a time when you can't work and what will you be then?"

Dr. Salmeron's love for orchids is his defining legacy. ❑

DocBookMD App Free To Members!

All physicians who are members of the Oklahoma County Medical Society will soon be able to sign up for DocBookMD, a HIPAA-compliant messaging app that allows physicians to communicate with each other about patients without violating HIPAA laws. The app is being provided for free to members of OCMS and the Oklahoma State Medical Association.

The app works on Smart phones and tablets so physicians can communicate at the point of care. It includes an up-to-date physician directory of members and listing of all pharmacies, can send and receive messages with images and photos such as X-rays, lab results, EKGs and wounds.

DocBookMD was created by two physicians, Dr. Tracey Haas and Dr. Tim Gueramy, and is currently in use in 23 states. All activity is run through a secure server with multiple encryption levels and the data is stored on the server, not the physician's mobile device.

OSMA is coordinating the launch of DocBookMD in Oklahoma. OSMA will offer a CME session on DocBookMD on Friday, April 19, during its Annual Meeting. For more information and to sign up for the CME session, please go to the OSMA website at www.osmaonline.org. ❑

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Meaningful Use Stage 2

S. Sandy Sanbar, MD, PhD, JD, Blake Christensen, DO, D. Wade Christensen, JD, J. Clay Christensen, JD, L. Nazette Zuhdi, JD, LLM, Adam W. Christensen, JD, MBA, Oklahoma City

On Jan. 1, 2014, Meaningful Use Stage 2 begins for ***eligible professionals (EPs)***. Physicians must develop strategies for meeting each of the following five Meaningful Use objectives, and talk to their vendors about plans and timelines for getting their ***electronic health record (EHRs)*** certified and upgraded.

1. ***Develop Web Portals for Patients.*** Physicians should sign up their patients to participate in a web portal linked to EHRs that give more than 50% of patients seen during the reporting period timely online access (within 4 business days of a visit) to their health records and allows them to message the physician securely. And, more than 5% of patients seen in that period must actually view, download, or transmit to a third party their health information. EPs will also have to demonstrate Meaningful Use for the entire calendar year, not just for the 90-day period required in Stage 1.

   Secure messaging might be built into the EHR. One may use an external messaging service like RelayHealth, which offers a certified EHR that includes patient-messaging features. Kryptiq is another external messaging service. Patients may also set up their own ***personal health record (PHR)*** on an external "platform" such as Microsoft HealthVault, which allows users of some EHRs to upload clinical data to patients' PHRs with their permission.

2. ***Exchanging Clinical Summaries.*** EHRs should be capable of generating a summary in a specific and mandatory format known as the Consolidated CDA, which can be shared with other physicians who use EHRs when exchanging clinical summaries with other providers during transitions of care, such as referrals and consultations. Some EHRs can currently create a similar summary known as the ***Continuity of Care Document (CCD)***. In Stage 2, EPs must

provide a summary-of-care record for more than 50% of transitions of care and referrals. In 10% of those transitions, the summary must be transmitted electronically using certified EHRs. EPs have to exchange a summary at least once with a recipient who uses a different EHR from that of the sender, or conduct a successful exchange with one of the Centers for Medicare & Medicaid Services-designed test EHR.

Some healthcare organizations and physician groups are acquiring internal ***health information exchanges (HIEs)*** that allow providers to send clinical messages and document attachments to one another. Other organizations may allow independent practices to join their HIEs. Alternatively, a private practice could join a community or regional HIE if one is available.

Direct Secure Messaging (DSM) protocol, created by a public-private consortium, specifies how a clinical message can be transmitted from one trusted party to another. Companies known as ***health information service providers (HISP)*** route the messages, maintain provider directories, and guarantee the authenticity of senders and receivers of information. DSM could provide independent physicians a cost-effective way to exchange summaries.

3. Laboratory Orders. Physicians should place laboratory orders themselves. More than 30% of laboratory and imaging test orders must be done electronically in Stage 2. Laboratories are expected to offer a two-way interface before 2014 in order to keep its customers. Physician groups should analyze workflow and figure out how best to place lab orders electronically, e.g. customizing template orders for annual exams that might include a blood panel, ECG, and bone density test.

4. Medication reconciliation. More than 60% of medication orders must be done electronically in Stage 2, compared with just 30% of prescription drug orders in Stage 1. When a patient is transferred to the care of an EP, the physician must use his EHR to reconcile the patient's medications in 50% of these care transitions. Vendors must build in this capability. Staffers will have to ask patients about their medications and capture that data in structured fields, and Surescripts medication histories can help as well.

*5. **Preventive care reminders.*** An EHR must have some kind of registry function that can identify patients who are due for preventive/follow-up care for more than 10% of patients with two or more office visits in the previous 2 years. The EHR must have a method of automating those alerts to patients; the office staff does not have to call or mail reminders. Third-party solutions do exist that help solve this problem if an EHR cannot do it. ❑

SAVE THE DATE!

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alliance

Introducing Alliance Leadership

Suzanne Reynolds and Kathy Bookman

The OCMS Alliance Leadership Ceremony was held January 16 in the Ceremonial Courtroom of the United States Federal Courthouse. The Honorable Timothy DeGiusti, United States District Judge of the Western District of Oklahoma, presided over the installation and administered the Alliance presidential oath of office to Suzanne Reynolds.

Suzanne then installed her new executive officers and board of directors. Outgoing President Kathy Bookman, passed the pin and gavel, and a celebratory luncheon was held at the Oklahoma Museum of Art Café.

2013 Executive Officers: Suzanne Reynolds, President; Kathy Bookman, ex officio; Amy Bankhead, President Elect; Hilda Kurkjian, Treasurer; Keith Oehlert, Treasurer Elect; and Paula Scott, Secretary.

2013 Board Class: Diane Brown, Cara Falcon, Nina Massad, and Mucki Wright.

2014 Board Class: Mary Delafield, Berna Goetzinger, Karen Gunderson, Barbara Jett, Linda Stewart.

2015 Board Class: Angela Chambers, Michele Davey, Elissa Norwood, Marni Sigmon, Kaisa Wallis.

Committee Chairs: Barbara Jett, Board Development and Governance; Mary Delafield, Communications; Jeary Seikel, Community Outreach and Special Events; Lauri Gormley, Programming; Jennifer Tortorici, Membership. ❑

Suzanne Reynolds, President

Correction: In the photo above, which ran in the January Bulletin, here is the correct information: Standing left to right are: Michael Flesher, Joni Flesher, Thomas Flesher IV, Thomas H. Flesher III, MD, and William Flesher. Seated left to right are: Bridget Thedorff and Lindsay Suttle.

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DIALOGUE

"A mentor is someone who allows you to see the hope inside yourself."
~Oprah Winfrey

Wednesdays With Murali

Many of you remember the popular 1997 non-fiction novel, *Tuesdays with Morrie*, written by Mitch Albom. In the book, Mitch recounts his "second chance" of reconnecting with Morrie Schwartz, a college professor from 20 years ago. Discovering Morrie in the last months of the older man's life, the author received the gift of valuable lessons about how to live.

In 2008, I walked the halls of the State Capitol with Dr. Murali Krishna every Wednesday afternoon during the legislative session in an effort to educate legislators about the necessity to pass legislation that would extend governmental tort immunity to health care professionals who gave the "gift" of their services to the uninsured in Oklahoma. SB930 passed both houses of state government and was signed by Governor Brad Henry. Many remember our success, but I remember so much more – the lessons Dr. Krishna taught me that I use to guide my life every day.

It was magical...seeing a person's response as Dr. Krishna approached them. Many were guarded at first, but their doubts quickly left as Dr. Krishna began to speak with eyes twinkling and a smile on his face. Someone once wrote that "the eyes are the windows to the soul," and this is true with Dr. Krishna. His goodness became apparent as they looked into his eyes. Dr. Krishna began by explaining how low income or uninsured citizens would benefit from the passage of this bill. His audience soon realized that he was not doing this to receive accolades for himself but rather to increase an uninsured individual's ability to obtain health care in a dignified way. My lesson learned was how to use energy from goodness to make a positive difference in my community.

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Move forward to 2013. The Health Alliance for the Uninsured, created from Dr. Krishna's desire to develop a coordinated health care delivery system for the most vulnerable in our society, has been selected to administer the Oklahoma County Community Health Network. To give you some history, Stanley Hupfeld, current HAU board president, was instrumental in developing a vision for the Commission to Transform the Health Care Safety Net in Oklahoma County. The Commission met monthly to evaluate current safety net services for low income and uninsured citizens and to learn about innovative models in other parts of the U.S. A Master Plan was designed for reducing fragmentation and improving health care services. The plan was ratified unanimously by Commission members in July 2012 and called for the development of the Oklahoma Community Health Network, which focuses efforts in three areas: specialty care, case management and strengthening of primary care medical homes within the safety net.

I want to thank the physicians of the Oklahoma County Medical Society who continue to support HAU's efforts to provide quality health care to low income and uninsured citizens in this community. To ensure the success of the Oklahoma Community Health Network, I ask specialty physicians who are not currently donating services through HAU to consider doing so. Many have asked if the passage of the Affordable Care Act will make HAU obsolete, and the answer is, "no." A need to deliver health care to the vulnerable will still exist. So, I encourage you to contact the Health Alliance for the Uninsured at 286-3343 and sign up to make a difference in your community.

I will never forget my Wednesdays at the State Capitol with Dr. Krishna. He is a treasure, and my life has been enriched just by knowing and working with him. Thank you so much, Dr. Krishna, for allowing me to "see the hope inside myself." ❑

Jana Timberlake, Executive Director

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals*	
	Dec '12	Dec '11	Nov '12	Dec '12	Dec '11
Campylobacter infection	3	2	3	55	61
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	0	2	0	25	24
E. coli (STEC, EHEC)	0	0	0	3	8
Ehrlichiosis	0	0	0	1	2
Giardiasis	0	0	0	0	1
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	1	0	2	17	10
Hepatitis A	0	0	0	2	2
Hepatitis B*	1	9	9	99	158
Hepatitis C *	2	10	13	229	192
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	0	0	5
Malaria	0	0	0	6	0
Measles	0	0	0	0	0
Mumps	0	0	0	0	1
Neisseria Meningitis	0	0	0	0	2
Pertussis	0	0	0	21	29
Strep pneumo invasive, children <5yr	0	0	1	7	5
Rocky Mtn. Spotted Fever (RMSF)	0	0	0	4	97
Salmonellosis	1	4	4	91	132
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	2	29	3	100	129
Tuberculosis ATS Class II (+PPD only)	24	34	54	463	541
Tuberculosis ATS Class III (new active cases)	4	0	2	29	28
Tularemia	0	0	0	0	1
Typhoid fever	0	0	0	0	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	55	0
Pediatric Influenza Death	0	0	0	0	0
Influenza, Hospitalization or Death	18	0	5	105	237
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	0	0	0	2
Legionella	0	0	0	2	3
Rubella	0	0	0	0	1
Listeriosis	0	0	0	1	3
Yersinia (not plague)	0	0	0	0	0
Dengue fever	0	0	0	0	0

YTD totals are updated quarterly to reflect cases that have a reporting delay due to laboratory confirmation or symptom assessment.

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

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

***Beginning in June 2012, medical health record was transitioned to the electronic format PHIDDO.

Data for newly identified infections is not available at this time. OSDH is being consulted on obtaining data.

CME Information

For information concerning CME offerings, please refer to the following list of organizations:

Deaconess Hospital
Contact: Emily McEwen
CME Coordinator
Medical Library
Telephone: 604-4523

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 Hospital OKC
Contact: May Harshbarger
CME Coordinator
Telephone: 752-3390

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

Oklahoma Academy of Family Physicians Choice CME Program
Contact: Samantha Elliott
Director of
Membership
Telephone: 842-0484
E-Mail: elliott@okafp.org
Website: www.okafp.org

OUHSC-Irwin H. Brown Office of Continuing Professional Development
Contact: Susie Dealy or
Myrna Rae Page
Telephone: 271-2350
Check the homepage for the latest CME offerings:
http://cme.ouhsc.edu

St. Anthony Hospital
Contact: Susan Moore
CME Coordinator
Telephone: 272-6748

Orthopaedic & Reconstruction Research Foundation
Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
Executive Director
Telephone: 631-2601

Help Improve the Bulletin

Do you have an interesting hobby? Do you write poetry? Are you an amateur photographer? Are you an artist? Do you volunteer on medical mission trips? Are you a mountain climber? Share your works and stories with your colleagues! The editorial staff welcomes – invites – your articles, poetry, letters and artwork for inclusion in the Bulletin. You may email them to tsenat@o-c-m-s.org or mail them to Tracy Senat, OCMS, Suite 2, 313 NE 50th Street, Oklahoma City, OK 73105. We look forward to hearing from you! ❑

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