Message From SCMS Councilor
Frank G. Dowling, M.D.

**PHYSICIANS COLLECTIVE NEGOTIATIONS PASSES SENATE!**

**LONG ISLAND PHYSICIANS ADVOCACY EFFORT CRITICAL TO THIS SUCCESS**

**ASSEMBLY LEADERSHIP PLANS TO MEET WITH MSSNY STAFF AND PHYSICIAN LEADERSHIP TO PASS COLLECTIVE NEGOTIATIONS THIS YEAR.**

By the close of the Legislative Session, the Physicians Collective Negotiations Bill S3186A (Hannon, et al)/A2474A (Canestrari, et al) had passed the Senate by a 43-19 margin, with bipartisan support. While the bill was not voted upon in the Assembly, it did move from the Assembly Insurance Committee to Ways and Means. The companion Assembly bill has about 70 co-sponsors, roughly half of the Assembly. Communications with Albany leadership including Speaker Silver’s office, Assemblyman Gottfried’s office, and Assemblyman Canestrari’s office have made it clear that they support collective negotiations legislation. In addition, communications with the Attorney General’s office and the Governor’s office have indicated support for collective negotiation legislation. However, in recognizing the importance and the historic nature of this unprecedented legislation, they want to take some time to address bill language and to assure that passage will not result in increased costs to publicly funded programs such as Medicaid.

Key Albany leadership has made a commitment to meet with MSSNY’s Division of Governmental Affairs (DGA) Staff and physician leadership over the summer weeks to address these concerns. The Assembly will return to Albany during the summer or fall to address unfinished business. At that time, it is hoped that they will bring collective negotiations legislation to a vote and passage. The Senate will then be asked to pass clean-up legislation that addresses Assembly leadership concerns. Then the legislation can go to the Governor for his signature.

Long Island physicians should be pleased to know that all 4 Senators in Suffolk County signed on as Co-Sponsors and that all 9 Long Island Senators voted for this legislation. There is no doubt that the activism of Long Island physicians was essential to getting the bill passed in the Senate. Doctors who called their Senators advocating for the bill should now call or write to thank them for their leadership in bringing this bill to passage.

This is the first time this legislation has passed either chamber in Albany. Physicians should be pleased and proud of their effort to bring this bill to passage in the NY State Senate, and should remain hopeful that this legislative goal can be achieved before the end of 2011. Physicians must be prepared to continue their successful advocacy efforts to assure that this legislation is passed by the Assembly and sent to the Governor’s desk for his signature this year.

In addition, Suffolk physicians should understand and appreciate the tremendous effort put forth by MSSNY DGA staff in Albany, including Gerry Conway, Liz Dears, Moe Auster, Pat Clancy and Barbara Ellman. The opposition to this legislation by the insurance industry was tremendous, and extremely well funded and worked daily to kill this legislation, but our staff remained vigilant, putting in 15 hour days, day after day toward the end of the legislative session. Their efforts kept this legislation alive and were critical to bring this legislation to passage in the Senate. No doubt they will be there for us throughout the summer as we work to address Assembly leadership concerns and to bring this bill to passage in the Assembly. Suffolk physicians should remember to let MSSNY DGA Staff know how much their effort on behalf of New York State physicians is appreciated.

Detailed information regarding the Physician Collective Negotiations Bill can be found on the web at www.scms-sam.org
**Suffolk County Medical Society Officers**
July 1, 2011 - June 30, 2012

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**Executive Committee Meetings**

**Upcoming Meeting Times & Dates**
All Meetings Begin at 6:00 PM at the SCMS Offices.

- September 7, 2011
- November 16, 2011
- January 11, 2012
- March 21, 2012
- May 23, 2012

**Board of Directors Meetings**
These are open meetings to all members. Please contact the SCMS if you would like to attend a Board Meeting so appropriate time can be provided on the agenda.

- October 12, 2011
- December 14, 2011
- February 15, 2012
- April 25, 2012
- June 1, 2012 (Annual Meeting)

**Suffolk Academy of Medicine Officers**
July 1, 2011 - June 30, 2012

- **PRESIDENT**: Richard S. Zito, M.D.
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- **SECRETARY**: Maria A. Basile, M.D.
- **TREASURER**: William R. Spencer, Jr., M.D.

**DATES TO REMEMBER:**
- MSSNY State Legislative Day (Albany): Tuesday, March 6, 2012
- Review of Resolutions: April 18, 2012
- MSSNY House of Delegates (Saratoga): April 20-22, 2012

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For more information, contact:
Jay B. Silverman, Partner and Chair of the Physician Practice and HIPAA Compliance Groups and Deputy Chair of the Health Law Transactional Group. (516) 663-6606, or jsilverman@rmfpc.com.

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Treat every day as a gift, unwrap it slowly and treasure it.
Dear friends, ladies and gentlemen, thank you all for meeting with us tonight. How does it feel to be a doctor these days? Doctors in NY have witnessed major changes over time. From snake oil in the 1800’s, to science and the ivory tower of medicine in the seventies, to Wall Street and Madison Avenue today. My perspective is somewhat different, in the fact that I have experienced healthcare in Europe, as well as in the US. My opinions tonight are personal and do not represent MSSNY policy.

In The Netherlands, my school offered advanced placement classes from grades 7 through 12. Classes were taking place from 8:30 till 4:30, from September 1st, through the beginning of July. Homework was limited to two hours. School was tough, family was fun. By the age of 17 to 18, at the time of graduation, most of us had completed what students here complete in College. We went straight to graduate school, in my case Medical School. I will say that I never had a teacher that I did not fully respect professionally, even as I failed English a few times. By means of the American Match program, I entered a surgery internship in NYC. I do not think that any other country has such an effective system to assign physician training positions as the American Match program. It is a clear reflection of how we, as a nation, try to be fair and efficient.

All four of my kids have shown an interest in becoming doctors. A little while ago, my daughter asked me; “Dad, how does it feel to be a doctor these days?” I would like to share with you some of my thoughts on the matter. College and medical school will cost her about $55,000 a year, after training (4 years for Internal Medicine) that loan will be $827,742 at 8% interest. My daughter, will be paying $83,082 a year, till age 50, to pay off her loan (or $72,000/year till age 65). She will most likely have to work for a Hospital or large medical group, and typically make $200,000, which sounds attractive. However, after loan payments and taxes, she will be left with $45,532 net income until age 50 (2011 rates in NYS). A UPS driver will do better than that. My daughter may try to compensate by adding other revenue streams like botox, or vitamins. Or she will perform work outside her specialty. But will that make her feel like a passionate doctor? Alternatively, some doctors are cash only, preventing many patients from seeing them. How will that make her feel? In short, my daughter will not be able to practice independently, and help the patients that need her most.

European physicians have seen an increase in their income since 1990. Currently, the average physician income in The Netherlands is 216,000 Euros, which today is $302,000 US dollars. They work on average just under 40 hours a week, and have no loan payments, no medication commercials in public media, and little if any malpractice insurance. Primary care doctors in England now are the best paid family physicians in Europe. As far as I can tell, I was one of the last physicians from Western Europe to come over; many from Asia are going back. Since 1990, in the US, income for physicians has remained flat. During this same period, tuition for young doctors has tripled, and their parents can afford it even less. The cost of education is not only wiping out doctors, the absence of effective and affordable education is having a negative impact on all our industries. A recent editorial in the Economist, considered America’s education deficit, a greater burden, than America’s budget deficit. It is our education gap that is keeping America from growing economically. The Ronald Reagan commission on education declared that if a foreign country were to impose the educational system we have upon us now, it would be considered an act of war. The American people, doctors, and folks, in all walks of life in this great country, are more productive than their European or Asian counterparts; except for our system of education. Doctors are expected to lay out up front the rising cost for education, and the declining reimbursement punishes doctors 16 years later. Physicians have gone from doctors, to providers, to prescribers, to foot soldiers for industry. The US, spent $2.3 trillion on the business of health in 2008, officially 6% of which goes to doctors (627,000 registered physicians with an average income of $238,000, working over 50 hrs/week). If we adjust for a 40 hr work week doctors receive 5% of all healthcare dollars. If we adjust for the cost doctors pay for education this drops to 3% ($72,000 per year for 35 years.) Add the cost of malpractice insurance, and doctors are left with 2% of the healthcare dollar ($35,000 per year, in New York, practicing internal medicine). I will leave for you to calculate the adjustment for the double and triple shifts during training and medical school. That result may turn out to be negative. We should also take into account the fact that a third of physicians were educated in foreign countries. Clearly, a physician will not recoup the investment if current trends continue. As state budgets decline, funds for education will dry up. In 2006, a republican Congress, and Senate under the leadership of William H. Frist, MD, was unable to pass malpractice reform.

(Continued on page 4)
Annual Meeting Inaugural Presidents Speech
Marc Yland, M.D.

Thus, these trends will continue for the foreseeable future. How are physicians trying to make ends meet? A recent article in the Wall Street Journal said that an orthopedic surgeon receives more from industry for using their implant, than from the patient fee. Many offices receive more lunches from companies than they buy themselves. Healthcare has become incorporated, doctors have been marginalized, and American life expectancy is falling behind Europeans, even as Europeans smoke twice as much. Blue Cross now pays less for visits and procedures than Medicare or Workman Compensation (for a 15 min visit: $52 less the co-pay of $10 -30, versus $81). Patients try to circumvent these insurance potholes by buying more expensive PPO insurance. The insurance than tells participating physicians that if they mention out of network treatments or referral they lose their contract. So insurance collects a large PPO premium upfront and then on the back end, insurance will treat you like a HMO patient and sell the patient the used parts.

How can you be a passionate doctor? Join MSSNY! Meanwhile, health insurance has become a Wall Street bonanza, and pharmaceuticals have become their own sector in the market. How many drugs solely developed by bigpharma are increasing the life expectancy of Americans? Was Vioxx better than Motrin, was Avandia better than Metformin? Is Oxycontin better than Morphine or Duragesic? Based on the commercials at the time, these medications would have rejuvenated anyone taking them. Why are recommended cholesterol levels lower in the US than anywhere else? A Harvard medical student was reprimanded for questioning a professor’s recommendation of certain brand name antidepressants. Is Sloan-Kettering really the best cancer care anywhere? Imagine the cancer patient hearing this commercial and knowing he or she cannot go there. How does it feel to be a doctor? Should I share with you the good news? A few weeks ago, I met with two gynecologist friends at Huntington Hospital; I also had lunch with a neurosurgeon last Friday. Amazingly, all three are helping one of their children through medical school. Only one of my colleagues saw a need to make education more effective. That is how it feels in my opinion to be a doctor. That is how it is to be a member of MSSNY. Thank you very much, and to the health of our country.

EMERITUS COMMITTEE DOINGS

Doctor Frank Dowling decided to talk about the doings of our Committee at an upcoming MSSNY Council meeting and our Executive Director, Stuart Friedman, plans to suggest that other counties throughout the state form Emeritus Committees.

Physicians generally wish to oversee the medical care of family and close friends. Older physicians often wish to continue in that function, and our Emeritus Committee serves to encourage that activity.

More than that, we wish to help our fellow physicians who are still in active practice.

We understand the great problems that physicians now face: With “The Health Care Collective Negotiation Bill of New York State” still undecided, the Obama Health Care Plan in flux, tort reform going nowhere, paperwork increasing and large insurance companies creating big problems for our doctors – our fellow physicians in active practice are in desperate need of new ideas! We would like to help.

At this time, the Committee is in an active effort to serve. During our last meeting in May, we discussed the MSSNY sponsored IPA and the Kaiser Permanente experience in this state, and why both failed.

At the June 20th meeting, we carried this further with other ideas, as it is our belief that these times of great flux are the best time for physicians to organize and prepare for new battles! Further, we believe that a little group, like ours, may be able to provide the catalyst for change.

Finally, the Committee wishes to thank the many physicians and the SCMS staff for encouragement and support.

Sheldon Feinberg MD
Chair
As someone who advocates on behalf of physicians, I am struck by the indifference of many practicing physicians with regard to our legislative efforts.

Policy and circumstance long ago conspired to shift control of the practice environment from physicians to their adversaries (mostly the government policymakers and commercial payers). Lately, these forces have led physicians increasingly to be employed by hospital systems and insurers, weakening both the individual and collective physician influence. Employed physicians, themselves, will be more vulnerable to the business vagaries of their employers, have less control of their practice ethics and environment, and have diminishing influence upon the political/regulatory environment. In addition, as the numbers of employed physicians begin to exceed those in traditional practices, the physician “stake” among all stakeholders will be diluted as well, rendering the traditional physician model more vulnerable as well.

It is no surprise then that the issues of great interest to physicians seem to be those that surround the economics of health care: PPACA, Physician Collective Negotiation and Out-of-Network Reimbursement.

- PPACA. Physicians are generally divided here. There is both strenuous support and strenuous opposition to the legislation. There are divisions among physicians on whether it is best to repeal the entirety of the legislation or to target just the most onerous of the legislation’s provisions. Consensus among physicians is evident only when physicians are asked which of the provisions are the most egregious. As there is great immediacy to reverse these provisions, physician agendas should focus on those immediate needs first. The government and payer stakeholders’ benefit (and physicians and patients are harmed) by inaction here.

- Physician Collective Negotiation – a bill has passed the NYS Senate that would allow for collective negotiation when certain market conditions exist (as they do in many New York markets). When enacted this would help restore some parity in contract negotiations between doctors and health plans.

- Out-of-Network Reimbursement – a bill that would: 1) restore transparency to patient out-of-network insurance contract benefits, and 2) relate those benefits to actual anticipated costs of out-of-network services (rather than a fee schedule) has been introduced. This would benefit both in-network and out-of-network physicians in that this legislation would prevent the institution of an insurance company “cap” on physician reimbursement. This legislation would promote meaningful negotiation between physicians and the plans and if no agreement is reached, limit the cost shifting to the patient.

Health insurers have never been bashful when it comes to exploiting the marketplace – whether to enhance their premiums or to pinch doctors in the name of reducing medical loss. They have (mis)used their monopsony power to enrich their own business interests, while at the same time failing their promise to contain health costs. But the recent emergence of hospitals and hospital systems as both potent negotiators and the predominant provider of physician services has surely not escaped their notice. In fact, it has become a threat to their business model. That’s why, at a recent dinner meeting, physicians representing a major payer asked if we could discuss our legislative agenda with them before we bring it to Albany. I’d say the other health care stakeholders are no longer indifferent to our legislative efforts.
MSSNY Chairman, Board of Trustees
Robert A. Scher, M.D.

There has been a severe and perhaps unexpected public reaction to an article by Robert Pear in the June 26 New York Times entitled, “U.S. Plans Stealth Survey on Access to Doctors.”

Mr. Pear wrote of the administration’s reaction to a known shortage of primary care doctors by using a team of “mystery shoppers” to snoop into your office to see how difficult it is to get care and to see if patients in government sponsored health plans had longer waits.

The snoopers were not to identify themselves as employees of the government. There was no mention of coordination with and asking for the help of primary care or any other physician organizations. The price was to be $347,370. The plans for the project were devised by Sherry A. Glied, an assistant health secretary and a big survey research company was retained.

On June 28 there was a follow up article entitled, “Administration Halts Survey of Making Doctor Visits.” The Department of Health and Human Services is quoted as saying they determined that, “now is not the time to move forward with this RESEARCH PROJECT.”

Another bureaucrat, Christian J. Stenrud is quoted as saying, “politics did not play a role in the decision.”

Your government and mine at its best. The question is, what happened in two days to direct Washington away from irresponsible action? Perhaps the risk reward ratio for snoopers was not in the administration’s favor with no reason to risk political capital. Could it be that the administration wanted to use the movement from this effort to boost non-physician extenders on the backs of the working physician but the fallout squelched the effort?

The denial by Mr. Stenrud reinforces the notion that there were back-room political forces brought to bear. You would want to think that in two days a concerted effort was organized and promulgated, with notification of Mr. Pear and further notification of multiple politicians with grassroots support. But this effort be-speaks of prior knowledge, and had to be orchestrated by someone big and the only relatively big friend we have is momma….our AMA. Could this be? Perhaps it’s time to rejoin, if you have dropped out.

Another recent happening was the budget fight in Albany with the Medicaid Reform Team requesting tort reform as a partial financial solution to the budget crunch to the tune of 177 million dollars. This was the first time I have seen a positive price put on tort reform by a New York Governmental Agency in recent memory. It brings to mind Art Fougner’s (Councilor from Queens County) resounding cry that, “tort reform is health care reform.” “You know political infighting with each man maintaining his number one priority in that back room with Cuomo, Silver and Skelos.” I want to point out what was most important to Mr. Silver. His constituency is a densely populated area of lower Manhattan with his number one priority to maintain a cap on the rise in rent for rent controlled apartments. Certainly it was not tort reform but we knew this going in. Another politician placed “caps” on property taxes and recently Mr. Cuomo astutely wove the legalization of gay marriage through the legislature. I would think this bill was part of the same deal.

What it tells us is that OUR political priority is still not the top priority of the big three. But I guess we already knew that. However it also tells us that we are not at the bottom which appears to be something new. It also suggests that perhaps an approach to Mr. Silver is through his constituents who need health care. Perhaps instead of just banging our drums, if we positively and effectively impact the health care they need with something new and startling (possibly by combining an effort such as a MSSNY induced health fair or the development of a medical home project as is in the Bronx) with a plan for a grassroots movement, then perhaps we will be fruitful. It’s worth a try as Mr. Silver does like to get reelected.

Remember TORT REFORM IS HEALTH CARE REFORM!
Badri P. Nath, MD, has just completed his term as President of the Suffolk County Medical Society. I would like to take this opportunity to personally thank Dr. Nath for his friendship, guidance, support and dedication during this past year. His concern and compassion for the medical profession is indeed laudable and deserves our praise and admiration. Dr. Nath has been instrumental in helping to cement relationships with our local legislators, most of whom view the SCMS as a resource for health-related issues being contemplated in Albany and Washington.

Following in the footsteps of John T. Mather Memorial and St. Charles Hospitals, Dr. Nath and Charles Rothberg, MD, have proposed an institutional membership initiative with the medical staff at Brookhaven Memorial Hospital. This exciting “out-of-the box” concept has been emulated by other county medical societies across the state. A special note of thanks is also extended to Philip L. Schrank, MD, President of St. Charles Hospital medical staff, and Kara H.V. Kvilekval, MD, President of John T. Mather Memorial Hospital medical staff for their dedication and support in assuring the success of this first-ever initiative at their respective hospitals.

The President’s page published in the society’s Bulletin during the past year has been thought provoking commentaries on the current status and future of health care in this country. Dr. Nath has been a friend and mentor to many of us who have sought out his knowledge and expertise during his presidency. Speaking for myself, I certainly learned a great deal due to his interest and involvement in medical society and physicians’ issues. Badri, thanks for all you have done for the society and for the members at large.

Marc J. Yland, MD, has been installed as the SCMS President for 2011-2012. Dr. Yland is board certified in anesthesiology and pain management and is on staff at a multitude of hospitals in Suffolk County. He has served on the Executive Committee, sits on the Board of Directors, has been the President of the Suffolk Academy of Medicine, and has been a delegate to the MSSNY House of Delegates for a number of years. I look forward to working with Dr. Yland during his presidency and am confident that the medical society will benefit from his knowledge and expertise.

There are still many physicians who have not paid their 2011 dues. Please, your dues dollars are extremely important. Without your continued support, our ability to fight on your behalf and on behalf of your patients will be severely hampered. Given the current economic environment in which physicians practice, we certainly recognize how difficult it may be to pay county and state dues. Please understand that members’ financial situations are always taken into consideration. Do not hesitate to contact us. Special accommodations can always be arranged.

One last note, ALL members are always encouraged to attend SCMS Board of Directors meetings. It is YOUR Society – Let your voice be heard. Please refer to page 2 for the schedule of Board meetings.

Seasoned manager in the physician services industry with extensive knowledge and experience dealing with management, billing and credentialing. I am a resourceful, highly organized and accomplished professional looking to obtain a position where I can maximize my management skills that will lead to a lasting relationship. In addition to the physician services, I have a broad knowledge of management involving retail sales with superior client service skills and analytical abilities. I can work independently in a matrix environment where priorities change rapidly and tight deadlines exist. Contact Robert Roth at 631-543-7266 or Roth6@verizon.net for a detailed resume and in depth outline of my work history.
PUBLIC HEALTH PAGE

From the Office of James L. Tomarken, MD, MPH, MBA, MSW, FACP, FRCPC
Commissioner of the Suffolk County Department of Health Services

MEASLES

Why are we concerned about measles?
On June 8, 2011 the New York City Department of Health and Mental Hygiene issued the following alert:

Thirteen cases of measles have been reported in New York City (NYC) since January 1, 2011. Five had no travel history or known exposure; eight traveled internationally to Europe and Asia.

On June 1, 2011 The New York State Department of Health Bureau of Immunizations issued a Health Advisory.

HEALTH ADVISORY: PREVENTING MEASLES IN NEW YORK STATE

During January 1–May 20, 2011, a total of 118 cases of measles were reported. To date (June 1, 2011), 11 cases have been reported in NYC and 5 cases of measles have been reported in New York State (NYS), outside of NYC, since January 1, 2011. Of the 5 cases outside of NYC, one case the patient had no travel history or known exposure, one infant travelled internationally to India, one was a traveler from France, and two cases were the result of emergency room exposures.

"The information below is a compilation and direct quote from the CDC, New York State Department of Health and Morbidity and Mortality Weekly Report (MMWR)." All travelers, children and adults, with destinations outside the United States (U.S.) should be up to date on their immunizations prior to travel. Measles outbreaks are common in both developed and developing countries, making the risk for exposure to measles high for many U.S. travelers. Infants 6 – 11 months of age who are traveling outside of the U.S. should receive a dose of measles, mumps, and rubella (MMR) vaccine prior to travel.

In addition, the CDC reported 7 cases in the following jurisdictions: NY (2), NYC (4), CA (1). Of the 7, three were imported and four were indigenous.

Susceptibility to Measles

The majority of cases of measles in the United States have been brought in from other countries, usually Europe and Asia but the CDC has noted some domestic cases. Travelers leaving the United States should be immune to measles. Although measles is usually considered a childhood disease, it can be contracted at any age by a person who never had the disease or been vaccinated. Unvaccinated individuals are 22 times more likely to get measles than those who have two measles vaccines, usually given as measles, mumps and rubella vaccine (MMR).

The single best way to prevent measles is to be vaccinated. Individuals should receive 2 doses of MMR (Measles, Mumps, and Rubella) vaccine to be protected. The first dose should be at 12-15 months of age and the second dose should be given at 4 to 6 years of age (age of school entry).

Individuals are not at risk of contracting measles if they are immune. A person is considered immune if they were born before January 1, 1957, have a history of physician-diagnosed measles, a blood test confirming immunity, OR have received two doses of the MMR (Measles, Mumps and Rubella) vaccine.

In order to prevent the spread of illness, the state and local health departments are also advising individuals who may have been exposed and who have symptoms consistent with measles to call their health care providers or a local emergency department before going for care. This will help to prevent others at these facilities from being exposed to the illness.

What can be done to prevent the spread of measles?

Maintaining high levels of measles immunization in the community is critical to controlling the spread of measles. Infected individuals should be excluded from work or school during their infectious period. Measles-containing vaccine should be provided to susceptible contacts within 72 hours of exposure. Immune Globulin (IG) can be given to susceptible persons within six days of exposure.

REPORTING DETAILS

Health care providers should increase their index of suspicion for measles in clinically compatible cases. The LHD should be notified of any suspect case immediately. Reports should be made at the time of initial clinical suspicion. If the diagnosis of measles is being considered and diagnostic testing for measles is ordered, then the case should be reported at that time. LHDs should also be notified of discharge plans from the health care setting. This is especially important if the case lives in a multifamily dwelling, dormitory, group home or has young children at home.

(Continued on page 9)
Welcome to our new applicants and thank you to the physicians who helped recruit them.

ACTIVE
Tzan-Wei Fang, M.D.
East Islip; Radiology
Recruited by Albert Zilkha, M.D.
Vlada Frankenberger, D.O.
East Setauket, Physical Medicine and Rehabilitation
Recruited by Philip L. Schrank, M.D.
Bruce S. Portner, M.D.
Riverhead; Internal Medicine
Eric A. Putterman, M.D.
Melville; Orthopedic Surgery
Sathish J. Subbaiah, M.D.
East Setauket; Neurosurgery

STUDENT
Darlinda K. Minor
SUNY @ Stony Brook

LABORATORY TESTING
Serology and viral specimens (urine or nasal-pharyngeal swab) should be obtained for diagnostic testing and confirmation. Use of commercial laboratories for measles testing may take up to a week for results. Reporting suspected cases of measles enables access to rapid testing through the NYS Wadsworth Center Laboratory. Viral specimens that result in a positive culture will be forwarded to the Centers for Disease Control and Prevention (CDC) for confirmation and genotyping.

MEASLES POST-EXPOSURE PROPHYLAXIS (PEP)
The successful initiation of measles PEP requires rapid intervention. LHDs can assist with the proper PEP recommendations and infection control measures. Measles vaccination should be administered to susceptible contacts of a measles patient within 72 hours of exposure and may offer protection. Immune globulin is indicated for susceptible household or other close contacts of patients with measles, particularly contacts younger than 1 year of age, pregnant women and immunocompromised persons, for whom risk of complications is highest. Immune globulin should be given within 6 days of exposure, to prevent or lessen the severity of measles.

MEASLES VACCINATION RECOMMENDATIONS
Children 6–11 months of age who are traveling outside the United States
Children ≥ 12 months, adolescents, and adults who are traveling outside the United States

ADDITIONAL INFORMATION
For additional information on measles outbreak control measures, clinical presentation and diagnostic tests, please refer to the CDC website at: http://www.cdc.gov/vaccines/vpd-vac/measles/default.htm.
The NYSDOH Measles Fact Sheet is available online at: http://www.nyhealth.gov/diseases/communicable/measles/fact_sheet.htm
Legal Page: From the Office of Ruskin Mouscou Faltischek, PC
Accountable Care Organizations: A Dangerous Regulatory Leap of Faith

By: Douglas M. Nadjari, Esq.

While the general public has focused its present health care, upon the controversial requirement that all citizens be required to purchase health insurance, the Patient Protection and Affordable Care Act of 2010 (“the Act”) raises potentially dire issues for physicians, physician groups, hospitals and consumers of medical care alike. The most vexing proposal calls for the creation of Accountable Care Organizations (“ACOs”). In general, the Act envisions ACOs as entities comprised of networks of doctors, physician groups and hospitals that somehow share collective responsibility for providing care to Medicare insured patients.1 Indeed, while member physicians need not be part of the same hospital system, they will be jointly required to manage the full spectrum of the health care needs of its Medicare insured members (a minimum of 5,000) for at least three years.

As a result of this ambitious initiative, the government estimates that ACOs may save Medicare up to $960 million in the first three years of the program and offer financial incentives for physicians to “buy in.” Proponents say that the ACO model allows successful participants to share in the savings if certain medical care quality objectives are achieved; if financial savings are demonstrated and if the organization implements programs that measure its clinical and cost-saving acumen. Here is another proviso: under existing plans, ACOs meeting benchmarks would not obtain their elusive share of savings for eighteen to twenty-four months after the ACO began investing in the program.

In addition to the very practical concerns with respect to start-up costs and profitability, regulatory landmines abound and the government has done little to explain: (1) how it will ameliorate potential “Stark” law conflicts posed by such arrangements, (2) the anti-kickback issues, and (3) potentially conflicting anti-trust and not-for-profit status issues that such “conglomerates” will inevitably raise.

Under newly proposed federal rules, there are two financial models: the “one-sided” model, in which the ACO benefits from the savings it generates (and is not penalized for having expenditures that exceed benchmarks) and the “two-sided” model in which the ACO also reaps a financial benefit from the savings it generates. However, under the two-sided model ACOs will be penalized for failing to meet clinical or financial “benchmarks.” Nonetheless, the Proposed Rule indicates that all ACOs will be transitioned to the “two-sided model in the third year of the program. Determining whether one can survive this “sea change” and, if so, which short-term model is viable is a daunting task and, absent further guidance— one conducted largely in the dark. Nonetheless, with either model, it appears that those unable to reduce cost or meet clinical benchmarks will suffer one fate or another: pay a penalty or simply perish.

In response to those who felt that the existing financial models were financially unrealistic, the Center for Medicare and Medicaid Services announced three new initiatives: (1) Development Learning Sessions (“DLS”), (2) Pioneer ACO Models, and (3) Advanced Payment Initiatives. The “DLS” consists of four lectures sponsored by CMS concerning existing ACOs in other jurisdictions. The Advanced Payment Initiative (“API”), will explore whether the government might provide a portion of future shared savings on a more expedited basis in order to encourage ACO start-ups. Finally, CMS has proposed what it refers to as a “Pioneer ACO Model,” designed “for health care organizations and providers that are already experienced with accountable care principles (i.e., Kaiser Permanente, the Geisinger Health Systems, the Mayo Clinic, Cleveland Clinics,) all of which had previously announced that they would not participate in the ACO program. Accordingly, to no one’s surprise, the program was introduced with highly favorable rules that would differ from other ACOs.

All agree that physicians should be charged with the responsibility of managing medical care, as the ACO plan calls for (and not HMOs, or hospital administrators). However, the success of these programs teeters upon not only the basic economic uncertainties raised herein, but upon a requisite yet illusory “best practice” standards (and less clinical testing), a new found culture of mutual trust and professional confidence amongst providers that do not even know -- much less trust one another-- all in the absence of any meaningful tort reform.

While the ACO initiative is set to take effect in January 2012, it is plagued by uncertainty and five inescapable facts: (1) no ACOs presently operate in New York State and we cannot predict how existing models may work here, (2) they place primary responsibility for patient health and well-being upon the physician who may not know or trust one another, (3) the extent to which physicians will benefit financially is questionable, (4) there are scant economic incentives to form ACOs that cater to those requiring high cost therapies or patients suffering from morbid conditions commonly found in the very populations ACOs will be called upon to serve, and (5) it provides little hope for the survival of solo practitioners or small practice groups that do not wish to be subsumed by large hospital systems.

(Continued on page 11)
In March, CMS issued proposed rules that addressed open issues with respect to the inclusion of certain provider types and suggested that ACOs be permitted to flexibility in formation (i.e., that they be permitted to be founded upon partnerships, joint ventures, group practices, etc.) so long as they do so within the framework of appropriate core competencies, reporting capabilities, and in a fashion consistent with state law.

In the final analysis, the goals are laudable, albeit speculative and illusory. Also, looming large over the entire debate is the fact that there are four cases winding their way -- very slowly -- to the U.S. Supreme Court that question whether the entire Patient Protection and Affordable Care Act of 2010 is an improper extension of the Commerce Clause of the Constitution. If the Act is declared unconstitutional the entire statute will fall and statutorily mandated ACOs will fall by the wayside as nothing more than collateral damage. If the statute passes constitutional muster and the pilot programs prove viable, ACOs may be here to stay.

Right now, the medical community is flooded with lawyers and consultants touting ACOs as the inevitable way of the future -- and they may be. In our view, it is simply too early to jump into such an endeavor unless you have a very high tolerance for risk (that cannot be accurately assessed) and access to capital required to form and finance an ACO until you prove to the government that your ACO is worthy of the illusory savings ACOs may offer. The “baby-boomer population continues to grow and there should be ample opportunity to form or join ACOs when the legal, clinical and financial pictures reach diagnostic quality.”

Doug Nadjari is a partner at Ruskin Moscou Faltischek where he is a member of the firm’s Health Law Regulatory Department and White-Collar Crime & Investigations Practice Group. Mr. Nadjari’s work primarily involves matters of physician discipline, hospital staff proceedings, managed care disputes as well as the defense of physicians and corporations in criminal, administrative and commercial disputes. He is a member of the Nassau County Bar Association, New York State Bar Association, New York State Association of Criminal Defense Attorneys and the New York State Medical Defense Bar Association.

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Insurance planning has become an integral part of the Estate Planning process. With the 2013 scheduled changes lowering estate tax exemptions (from $5,000,000 to $1,000,000 per person) and raising estate tax rates (from 35% to 55%), reviewing your insurance programs in conjunction with your estate tax plans is a necessity. Not only should you re-evaluate how much insurance you will need for estate tax planning, but also how much money can be saved on your existing plans!!!

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   **Savings Tip:** Check to see if your permanent insurance programs include a guaranteed death benefit by calling your insurer and asking for a “guaranteed illustration.”
   
   Review the illustration with an insurance professional to determine your options.

3) **Savings For New Classifications of Insureds:**
   
   Most insurers have generously discounted the premiums of many policies for those applicants who are in excellent health. Even for those who are not in the best of shape, insurance rates due to reductions in mortality experience costs and operating expenses, have also declined. However, these savings would not apply to someone whose health has deteriorated significantly and is considered uninsurable.
   
   **Savings Tip:** If you’ve lost weight, stopped smoking, your health has improved or even stayed the same from when you previously purchased your insurance plan, this might be the time to reapply to obtain a cost reduction in your insurance program.

Additional **Savings Tips:**

A. Never drop existing coverage until new coverage is obtained and bound.
B. Take your time in evaluating which plan makes the most sense for you and your business or family.
C. Try to choose a plan that can be flexible to accommodate your changing needs. For example, selecting a 20-year term plan with a conversion feature allows you the option to retain the plan your entire life by conversion.
D. Use the Internet to obtain pricing and product information.
E. Don’t “go it alone” — work with an insurance professional to help you make an informed and educated decision regarding your insurance options.

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More Than Swells The Eye

The air conditioner fan banging made it clear that it was not working. As the sweat dripped down my face, all I could think about was jumping into the clear, blue water of the Caribbean Sea. Yet, of course, only my family would fly into the wrong “airport”, which was only a dirt road and a hut. My dad, always a talker and rambler, continued to helplessly converse with the taxi driver who clearly knew no English. Behind him sat my mom, complaining and moaning about the dreaded heat; my sister just slept. With nothing else to do, my iPod and I shuffled across the countryside.

About to fall asleep, my head suddenly slammed against the driver’s headrest as the taxi driver swerved to avoid a dead cow in the middle of the road. Flies splattered against the window like a Jackson Pollock and the tires began to screech. Typical of family, my dad kept gibbering, my sister kept snoring, my mom was whining, and I was still dreaming about the beach.

Then I saw him on the side of the road. With his baby sister in his arms, stood a young boy around my age. As my iPod cheerfully played, I began to realize the child’s eye was swollen shut. His eye, purple as a plum, made the pain palpable. He had no shoes on, was wearing rags and stood beside a dog that looked almost as scrawny and weak as he was. Undoubtedly, his eye begged for serious medical treatment. The taxi driver continued to speed through the small town and the children vanished from my sight.

For something that lasted only a few seconds, this is the moment that sticks in my mind every time I put on my maroon vest and walk into the Brookhaven Memorial Hospital. Being an Emergency Room Ambassador has affected my life in many ways. My responsibilities within the hospital not only fill me with a great sense of purpose and leadership but also make me a more social and prepared individual. Seeing other people suffering has a unique way of not only activating sympathy, but also triggering strength and perseverance. On my first day of volunteering, I walked into the hospital feeling some nervousness, yet the tension was quickly overshadowed by an image in my head; the boy with the swollen eye holding his baby sister in his arms.

Underneath the dust and debris of the Dominican Republic, was an unknown child, who revealed to me a new perspective on life. This discovery has enabled me to see that the greatest thing one can do in life is to put others before themselves. From this experience and the knowledge I will attain, starting a career in the medical field will allow me to shine through the dust of other countries; hopefully changing lives to the degree mine has been changed.
2011 House Delegation: (Left to Right) Bruce Berlin, MD; Richard Zito, MD; Marc Yland, MD; Bernard Lane, MD; Nabil Kiridly, MD; George Ruggiero, DO; Frank Dowling, MD; Robert A. Scher, MD.

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Physicians, Practices and Social Networks – Gauging the Risks

By: Michael J. Schoppmann, Esq.
Kern Augustine Conroy & Schoppmann, P.C.

As physicians react to the growing market pressures to grow and/or maintain their patient populations, many are embarking upon an entry into the world of social networks. While such environments may hold great reward for many businesses, they also hold many concerns and risks unique to physicians and their medical practices.

A “Social Network” is defined by dictionary.com as an online service, platform or site wherein “family, friends and their families, that together create an interconnected system through which alliances are formed, help is obtained, information is transmitted, and strings are pulled. In an organizational setting, it usually constitutes the group of one's peers, seniors, and subordinates who provide information on how to get things done, how the power structure operates, and who holds the strings.”

The number of social networks continues to grow exponentially every day and a social network heavily favored one moment may quickly find itself an afterthought or viewed as outdated the next moment. Examples of social networks are illustrated in the chart below:

Seemingly attractive, an increasing number of physicians interacting within social media are creating some notable, and dire, consequences. As exposed by the Journal of the American Medical Association, a large number of medical students have admitted to using the forums inappropriately to discuss individual patients. Other recent incidents have involved a physician’s office staff posting entries on Facebook and/or Twitter complaining about “difficult” patients and in one case, a Boston pediatrician who blogged throughout his malpractice trial.

Before any physician contemplates their entry into this new, ever evolving environment, they should consider certain preemptive risk management factors before doing so, such as:

- Is the practice prepared to devote ongoing time and capital to this environment?
- Is the practice prepared to vigorously monitor the information posted in response?
- Is the practice committed to routinely updating the information posted?

Absent positive responses to the above noted factors, physicians and medical practices would be better served to withhold their entry in the realm of social media until such time as they are prepared to provide a strong commitment to the demands of social networking. Absent such a commitment, a partial or half-hearted effort will only leave the practice exposed to not only potential liabilities but adverse Internet “standing.”

(Continued on page 19)
It is with deep regret we announce the passing of Arnold A. Urist, M.D., died May 22 at the age of 77.

He was an attending physician at Eastern Long Island Hospital in Greenport for 34 years, where he served as chief of medicine in the late 1970s. He was also an attending physician in internal medicine at Peconic Bay Medical Center in Riverhead. He retired from his medical practice in December 2004.

Dr. Urist is survived by his wife of 49 years; his daughters, Andrea, of Brooklyn, and Theresa, of Cambridge, Mass.; his son, Daniel, of Boulder, Colo.; his sister, Irene Simon of the Bronx; and three grandchildren.

If the practice or physician decides to engage in social networking, a large degree of advance planning and the assigning of structural responsibilities must be considered, such as:

• Who creates the data to be entered?
• Who physically (and routinely) enters the data within the network (and updates the data)?
• How often is the data reviewed and authorized by the physicians of the practice?

Regarding the actual data posted within a social network itself, physicians and practices must also be mindful of standards and/or codes of conduct they are bound to abide by – not only those required by the social network itself, but also those required exclusively of physicians. Issues such as patient confidentiality under state and federal law (HIPAA), conduct requirements under state licensing requirements (boundary violations), contractual terms under payor (both public and private) and the general obligations of law (i.e., prohibiting defamation, libel, etc.) all dictate that great care be taken, especially for physicians and medical practices, as to the actual content within a social network and vigilant scrutiny over the ever changing/updating data.

For even those practices which might decline to pursue efforts within social media, caution should be held over the activities of employees of the practice. Use of personal e-mail accounts while working should be strictly curtailed due to the growing number of unintentional and intentional violations of patient-privacy laws. Moreover, many disgruntled former employees use social networking sites to disparage the practice and/or solicit present employees to join pending workplace claims. Moreover, an increasing number of workplace claims (i.e., harassment, stalking, cyber-bullying, discrimination, hostile work environment, etc.) are originating from social media (Facebook, etc) interactions between employees. To risk management such threats, every medical practice should develop, adopt and issue a written set of detailed policies addressing these issues and prohibiting the crossover of their role (and responsibilities) as employees and social networking. Such policies should be reviewed directly with all practice staff, updated routinely and acknowledged in writing, by every member of the practice.

In conclusion, while not prohibited directly by law or regulation, any environment which holds unknown risks and is ever changing at a breathless pace, should be disquieting to physicians and medical practices alike. Unlike other forms of business, the practice of medicine carries an extremely onerous degree of oversight and an increasingly powerful body of restrictions. As a result, the best risk management tool for medicine may well be to simply not enter the world of social media until society sets the permissible boundaries to do so.
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