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Outgoing MCMS President, Adrian Christie, MD (left) accepting a plaque of appreciation from incoming MCMS President, Gary Shapira, MD at the Annual Meeting on November 18, 2014

Macomb County Medical Society
P.O. Box 62
Yale, Michigan 48097-0062

Macomb Medicus

Journal of the Macomb County Medical Society
810-387-0364
Toll Free 877-264-6592
Fax 810-387-0372
e-mail mcms@msms.org
web www.macombcms.org

IN THIS ISSUE

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Home Theater and Health Care Reform *(Part One)*

By: Gary L. Shapira, MD
MCMS President

WHY HOME THEATER?
Home theater is a great hobby. Instead of spending bucks to get inundated with commercials and popcorn on your shoes, home theater is available anytime with no limits. Too loud? You control the volume. Parking? No problem. Dirty bathrooms? Not a chance. Noisy neighbors? Never. Cell phones? Only yours. So you see, I really like home theater.

WHY HEALTH CARE REFORM?
American health is substandard. We spend a massive amount on medical care, but the results are unsatisfactory. There are too many obese and unhealthy. Our mortality statistics are not acceptable. Health care reform is to eliminate the uninsured, increase quality, and lower cost.

HOME THEATER INFRASTRUCTURE.
The first step in home theater is deciding what you want your home theater to be able to do. How big is your room? How many seats do you want? How loud do you want? What source media do you want? What system control do you want? Once you decide the basics of you home theater, getting the equipment is easy. There are lots of salesmen who will help you buy what you need.

HEALTH CARE REFORM INFRASTRUCTURE.
The American health care infrastructure is already in place. The United States has trillions of dollars invested in hospitals and other facilities. Our doctors, other health care personnel, and hospitals are the best on the planet.

HOME THEATER SET-UP.
This is how the infrastructure produces results. Setting up a home theater is work and benefits from experience. Not infrequently, a salesman at Home Theater Equipment Inc. arranges installation. Or you can set-up your own home theater.

HEALTH CARE REFORM SET-UP.
This brings us to the Patient Protection and Affordable Care Act (ACA). Signed by President Obama on March 23, 2010, the ACA is meant to organize the matchless infrastructure of American health care to eradicate the problems of cost, quality, and availability. One of the medical organizations encouraged by the ACA is the accountable care organization (ACO). Basically an ACO seeks to lower cost and improve quality by paying providers more for lower cost and improved quality. Except for a few pilot studies, ACOs have been restricted to Medicare patients. ACOs contract to participate for at least three years. There are two payment models. In the one-sided model, providers share in any savings over a 2% threshold and share in losses in the third year only. In the two-sided model, providers share in all savings and losses for three years. There are 360 Medicare Shared Savings program (MSSP) ACOs approved through December 2013. More are on the way. Also mandated by the ACA are standards for what insurance covers, penalties for not being insured, and the formation of health insurance exchanges.

This article is entitled Home Theater and Health Care Reform (part one). Why part one? Because health care reform is a big topic. One part is not enough.

EBOLA AND MICHIGAN'S PREPAREDNESS FROM MDCH

By: Scot F. Goldberg, MD; Adrian J. Christie, MD; Betty S. Chu, MD; Michael A. Genord, MD; Donald R. Peven, MD; David P. Wood, Jr., MD

While there is no current threat to Michigan, and we hope Ebola does not come to our state, we know that coordination and communication are the keys to preparedness. As the Michigan Department of Community Health works to be vigilant against any threat this virus, and other infectious diseases, may pose to our state and its citizens, communication to our members is key to Michigan's response.

According to a news release, the top priority of Governor Snyder and the Michigan Department of Community Health is to safeguard the health and safety of Michigan residents, including the healthcare professionals who care for them. It is paramount that we protect those who put their own safety on the line by caring for those who are infected.

MDCH has been meeting with their healthcare partners, including front-line workers, to assess their ability to respond in the event of a case of Ebola in Michigan, and to learn directly from them about the preparedness efforts in their facilities. During these meetings, they are working to ensure that proper information and training is available to healthcare professionals, including knowledge about the use of personal protective equipment (PPE), and ways in which they can support their efforts.

MDCH and its Office of Public Health Preparedness have had emergency response plans in place for more than a decade, as well as well-established and effective surveillance and communication processes. Further, their state laboratory is one of only 14 laboratories in the nation with the capabilities to complete testing of suspected Ebola cases. Having these resources greatly increases Michigan's ability to respond quickly and accurately.

MDCH knows our members are vital partners in their preparedness efforts. With the resources available in Michigan, as well as the coordination which has been taking place, MDCH is available to assist and ready to respond in the event of a case of Ebola in our state.

NEW CHILDHOOD IMMUNIZATION GUIDELINES WILL MEAN HEALTHIER, SAFER MICHIGAN

The Michigan Joint Committee on Administrative Rules (JCAR) has approved new childhood immunization guidelines developed by the Snyder Administration.

With the new rule taking effect January 1, 2015, any parent wishing to get a vaccination exemption for their child will now be required to visit their local health department to receive information and education before signing the exemption form.

The new rule reads: "Each non-medical exemption filed at the child's school or group program of a child entering a program after December 31, 2014, shall be certified by the local health department that the individual received education on the risks of not receiving the vaccines being waived and the benefits of vaccination to the individual and the community. All waivers shall be submitted using the waiver form prescribed by the department."

HIGHER DEATH RATES, MEDICAL BILLS FOR MICHIGAN MOTORCYCLISTS WITHOUT HELMETS

Since Michigan repealed its motorcycle helmet law in 2012, roughly one in four riders now choose to let their hair blow free.

The annual cost of that freedom: roughly two dozen more deaths, scores of additional serious injuries and a huge spike in average medical expenses, according to studies of motorcycle crashes in Michigan.

The numbers underscore what law-enforcement and medical data have shown for years - that riders without helmets are more likely to die or suffer serious injuries in a crash than riders who wear helmets.

LEGAL INS AND OUTS OF MANDATORY FLU VACCINE POLICIES

More and more health care employers are requiring that all employees get the influenza vaccine in order to help protect patients and coworkers during flu season. Additionally, the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers get vaccinated annually against influenza.

If you or your workplace are considering implementing a mandatory influenza vaccination policy for employees, it is important to understand the legality of such policies, as well as various nuances to ensure proper implementation. Employers may adopt mandatory flu shot policies which are drafted and implemented in a legally compliant manner.

Visit www.msms.org to read more from MSMS Legal Counsel.

MICHIGAN STATE LOAN REPAYMENT PROGRAM

The Michigan State Loan Repayment Program (MSLRP) assists employers in the recruitment and retention of medical, dental, and mental healthcare providers who continue to demonstrate their commitment to building long-term primary care practices in underserved communities designated as Health Professional Shortage Areas (HPSAs). MSLRP will assist those selected by providing up to $200,000 in tax-free funds to repay their educational debt over a period of up to eight years. Participants will enter into consecutive two-year MSLRP service obligations requiring them to remain employed for a minimum of 40 hours per week for no less than 45 weeks per year at eligible nonprofit practice sites providing primary healthcare services to ambulatory populations.

Please see the below MSLRP Program Opportunity Update for more information on the following:

- New Application Period: January 1, 2015 to April 30, 2015
- Selection Preference for Prompt Submission of Complete Applications
- Participation Increases to Eight Years with Total Loan Repayment up to $200,000
- Providers Who've Completed Four Years of MSLRP Participation May Now Reapply
- Program Requirements and Selection Criteria: Northern OB Providers Remain Priority
- MSLRP Continues to Encourage Employers to Use Provider Retention Plan
- Providers Also Applying to the National Health Service Corps Loan Repayment Program

If you have questions about the Michigan State Loan Repayment Program, please contact Ken Miller at (517) 241-9946 or MillerK3@michigan.gov .

BCBSM PGIP SPECIALTY FEE UPLIFTS IN 2015

Blue Cross Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program (PGIP) continues to grow and to evolve. PGIP initially focused predominantly on building primary care infrastructure; however, over the past few years, there has been increased emphasis on bringing specialists into the PGIP mix. The Michigan State Medical Society (MSMS) has dedicated a tremendous amount of time and effort to successfully advocating that BCBSM expand the number of specialty physicians eligible to receive increased professional fees (a.k.a, fee uplifts) and include specialty societies in the identification of appropriate quality metrics used for selection by BCBSM.

In 2014, the number of eligible specialties eligible for fee uplifts increased from 7 to 24. BCBSM reports that in 2015

all specialties except for anesthesiology* will be eligible for fee uplifts in PGIP. The inclusion of specialists in BCBSM PGIP specialty fee uplifts is intended to help promote the evolution of the Patient-Centered Medical Home (PCMH) to the PCMH "neighborhood" (PCMH-N) in which specialists are actively engaged in transformation efforts including enhanced interaction and coordination with their respective PCMH partners.

To be considered for a fee uplift, a specialty practice must be nominated by their Physician Organization (PO) or by a PO in which the majority of their patients are attributed. Nomination does not guarantee that a practice will receive an uplift. Determinations are made annually based on one or more metrics of quality, utilization, efficiency, and cost performance. Most measures look at population-level performance versus practice-level performance. Fee uplifts are effective beginning in February of each year and are applied to PPO traditional commercial claims.

In 2014, approximately two-thirds of the nominated practices in eligible specialties received an uplift (10% for the top third and 5% for the second third). This designation will change in 2015, with only the top half of ranked, fully nominated practices receiving either a 10 percent fee uplift (top quartile) or a 5 percent uplift (second quartile). The decision to adjust the threshold is largely budget driven. While more total dollars will be dedicated for uplift financing, they will be distributed amongst a larger pool of specialists. Instead of "watering down" the amount of the increase, BCBSM chose to keep the tiered uplift amounts the same and increase the selection threshold. BCBSM predicts that the number of specialists receiving uplifts will increase from more than 5,000 in 2014 to more than 6,000 in 2015.

It is important that specialty practices communicate with their affiliated POs to determine the status of their nominations.

If you have additional questions regarding PGIP, please contact your BCBSM Provider Consultant or Stacey Hettiger, MSMS Director of Medical and Regulatory Policy, at (517) 336-5766 or shettiger@msms.org.

**BCBSM has indicated that anesthesiologists will not be included at this time due to the manner in which they are reimbursed.*

Adrian Christie, MD & Barb Rossmann, President, Henry Ford Macomb Hosp.

Josh Richmond from MSMS

Terry Hamilton, President, St. John Macomb Oakland Hosp. & Gary Shapira, MD

THE MACOMB COUNTY MEDICAL SOCIETY HELD ITS ANNUAL MEETING ON TUESDAY, NOVEMBER 18 AT THE STERLING INN.

Our guest speakers were Josh Richmond, Director of Membership and MD-PAC at the Michigan State Medical Society; Terry Hamilton, President of St. John Macomb Oakland Hospital; and Barbara Rossmann, President of Henry Ford Macomb Hospital.

During the meeting, President-Elect, Gary Shapira, MD presented outgoing President, Adrian Christie, MD with a plaque of appreciation, on behalf of the MCMS Executive Board, for his service to the society.

Adrian Christie, MD & Terry Hamilton, President, St. John Macomb Oakland Hosp.

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Henry Ford Macomb Hospital

BEAM SIGNING CEREMONY MARKS MILESTONE IN EXPANSION PROJECT

Approximately 40 Henry Ford Macomb Hospitals leaders, supporters and community partners, along with several local officials attended a "beam signing" to celebrate a milestone in the Surgical Services Expansion Project and to kick off a capital campaign to raise funds for the second phase.

On Oct. 13, the group was invited to sign one of the final support beams that will be placed in the new structure and learn more about the project. Approximately 300 hospital employees had already signed the beam.

Several Henry Ford Macomb Hospitals leaders and supporters were on hand to celebrate a milestone in the Surgical Services Expansion Project, including, from left: Medical Director of Cardiothoracic Surgery and capital campaign co-chair Steven Harrington, MD; capital campaign co-chair and volunteer Tony Rubino; State Representative and Ambassador Club of Henry Ford Macomb Hospitals member Marilyn Lane; Henry Ford Macomb Hospitals President and CEO Barbara Rossmann; Henry Ford Macomb Hospitals Board of Trustee member and Philanthropy Committee chair Tony Viviano; Henry Ford Macomb Hospitals Board of Trustee member Andrea Wulf; Pete Lucido, volunteer and friend of Henry Ford Macomb; and Board of Trustee member and Ambassador Club member Ray Lope.

A $15 million capital campaign to complete Phase 2 of the expansion project is underway. Campaign co-chairs Steven Harrington, MD (left), Medical Director of Cardiothoracic Surgery, and volunteer Tony Rubino sign the beam.

Hospital News continued on pg. 10

SURGICAL SERVICES EXPANSION PROJECT FACTS

Many of the region's top surgeons perform procedures at Henry Ford Macomb Hospital, continuing to introduce the latest advancements and bringing the best care close to home for their patients. In recognition of our community's growing needs, and our surgeons' commitment to this region, Henry Ford Macomb is investing in a multi-year, two-phase expansion project.

Phase 1 - First floor Surgery and Endoscopy Center, which is primarily outpatient or same-day surgery. Improvements include:

- State-of-the-art Urology Imaging System. It is designed to assist Henry Ford Macomb urologists in the diagnosis and treatment of all urological disorders, including kidney disease, bladder disease, kidney stones and prostate diseases.
- Bringing two additional operating rooms online - including a region-leading Retinal Surgery Program. This would bring the total number of operating rooms in the Center to nine.
- Expansion of pre- and post-operative holding areas.
- New elevator tower.
- New, expanded associated support space.
- In addition, Phase I includes framing in of the expanded second floor space that will house the larger second floor operating rooms that will be built in Phase 2.

Phase I is being funded by Philanthropy from generous community donors.

Phase 2 - Encompasses work on an expanded second floor surgical area. Changes will include:

- Expansion of the seven existing surgical suites to 650 square feet each, allowing for more complex surgeries. Current industry design recommendations are 500 to 650 square feet for standard surgical suites, which is large enough to accommodate medical equipment and staff needed for most types of surgeries.
- A new state-of-the-art Hybrid Room, the first of its kind in Macomb County. The Hybrid Surgical Suite allows for minimally invasive surgeries, endovascular interventional procedures, and traditional open procedures to take place in the same operating room. Surgeons also would have access to the most advanced imaging technology, right in the operating room, providing real-time details that result in more accurate treatment and safer, shorter procedures for the patient.
- New technologies and advanced surgical equipment. The expansion will allow for new and ever changing technologies. By increasing the size it will also allow space for more complex surgeries and advanced surgical equipment.

HENRY FORD MACOMB NAMED 2013 TOP PERFORMER ON KEY QUALITY MEASURES™ BY LEADING ACCREDITING AGENCY

Henry Ford Macomb Hospital has been recognized as a 2013 Top Performer on Key Quality Measures™ by The Joint Commission, the leading accreditor of health care organizations in the United States.

Henry Ford Macomb is the only healthcare organization in Macomb County to receive the distinction. The hospital was recognized as part of The Joint Commission's 2014 annual report "America's Hospitals: Improving Quality and Safety," for attaining and sustaining excellence in accountability measure performance for:

- Heart attack
- Heart failure
- Pneumonia
- Surgical care

"Our patients expect and deserve the absolute highest quality care delivered in the safest possible manner," notes Barbara W. Rossmann, President and CEO of Henry Ford Macomb Hospitals. "That is why we have made it a top priority to continuously improve patient outcomes through evidence-based care processes. We are proud to be named a Top Performer as it recognizes the knowledge, teamwork and dedication of our physicians and entire clinical staff."

The Top Performer program recognizes hospitals for improving performance on evidence-based interventions that increase the chances of healthy outcomes for patients with certain conditions, including heart attack, heart failure, pneumonia, surgical care, children's asthma, stroke, blood clots and perinatal care, as well as for inpatient psychiatric services and immunizations.

To be a 2013 Top Performer, hospitals had to meet three performance criteria based on 2013 accountability measure data, including:

- Achieving performance of 95 percent or above on every reported element in which at least 30 patients were treated;
- Achieving an average performance of 95 percent or above across all reported elements;
- Having at least one diagnosis that had a composite rate of 95 percent or above within all applicable individual elements.
- Delivering the right treatment in the right way at the right time is a cornerstone of high-quality health care. I commend the efforts of Henry Ford Macomb Hospital for their excellent performance on the use of evidence-based interventions," said Mark R. Chassin, MD, FACP, MPP, MPH, president and CEO, The Joint Commission.

TACKLING LUNG CANCER: HENRY FORD MACOMB LEADS REGION IN PREVENTION, DIAGNOSIS AND TREATMENT

Stop smoking. That is the single most important thing to remember to prevent lung cancer. It is linked to at least 80 percent of lung cancer deaths.

More than 750 Macomb County residents are diagnosed with lung cancer each year. Unfortunately, lung cancer is typically diagnosed at a late stage. Almost 60 percent of all lung cancers are diagnosed as metastatic - cancer that has traveled from the primary site such as the lung, to one or more distant sites in the body where it continues to grow. The five-year survival rate of the most common type of lung cancer found at this stage is only 1 percent.

The need for prevention and early detection is clear. In January, Henry Ford Macomb began offering current and former smokers most at risk for lung cancer an affordable option to be screened for the disease. Since then, 102 community members have taken advantage of lung cancer screening in the form of a CT scan that uses advanced, low dose technology to reduce the radiation risk.

Henry Ford was part of a national study in 2010 that found CT screening reduced deaths from lung cancer by 20 percent, compared to those screened with chest X-rays. To learn more, go to www.henryford.com/lungscreening.

A patient speaks out

Al Logocki, 67, is still recovering from his second bout with lung cancer, but he's also upbeat and grateful for the physicians, clinical staff and technology at the Josephine Ford Cancer Institute at Henry Ford Macomb Hospitals.

"The doctors are great," said the Warren resident. "When I found out I had cancer again, I was scared. Everyone thought I was cured, but it came back."

In 2008, Al had surgery and radiation to treat cancer in his left lung. Cancer patients are followed for a number of years. In November 2013 a test revealed recurrent cancer in the right lung. He received an endobronchial ultrasound guided biopsy and chemotherapy. In April he underwent a surgery to remove the tumor and a portion of his lung. He said although chemotherapy was difficult, he feels like he could not have asked for better care. He said the staff and setting at the Infusion Center eased his fears about chemotherapy. He liked the calm and private atmosphere and the staff was exemplary.

Al said his most recent x-ray was clear and he was able to get back to normal activities such as golfing over the summer. His advice to everyone: "Don't smoke. It just isn't worth it."

Rapid, precise diagnosis

Al's story shows that it takes a whole team to ensure patients receive individualized care for a complex diagnosis that can involve an array of intricate treatment options. For some, the process may start with a lung cancer screening or a work up from a pulmonologist.

"I look at the CT scans and the reports and determine the need for further follow-up," says Rajindar Sikand, MD, Medical Director of Respiratory Services and Pulmonary Function. "I think we will see over time that these screenings are going to bring more and more patients to us with lung cancers that are in earlier and more treatable stages."

New technology such as endobronchial ultrasound (EBUS) provides physicians and other clinicians a non-invasive method to look at the lung and lymph nodes in and near the lung. In addition to diagnosing and staging lung cancer, an endobronchial ultrasound may also be used to detect infections, or help to diagnose other lung conditions.

If the diagnosis is cancer, patients enter the Multidisciplinary Lung Cancer Treatment Program, where they are shepherded

through the process of diagnosis and treatment by a nurse navigator.

Tumor boards meet regularly to talk about cases and plan the best course of treatment.

Treatment plans that work

"The patient comes first so you have to put together a treatment plan that cares for the whole patient and their family," says medical oncologist Michael Henderson, MD. "We have the physicians, staff and facilities to care for even the most complex cancers here and we take full advantage of that. Being part of the Josephine Ford Cancer Institute, we have access to cancer subspecialists should we need them."

Whether it is biologic agents or chemotherapy, treatments are tailored to each patient's needs.

If surgery is possible, Henry Ford Macomb has two thoracic surgeons on staff to treat lung cancer patients - Steven Harrington, MD and David Sternburg, MD. Dr. Sternburg notes that many patients now have minimally invasive options. Whenever possible, Dr. Sternberg uses small incisions between the ribs.

"This approach minimizes pain," he said. "That can be very important because it allows patients to go home faster, with fewer medications and to return to their lives sooner."

If radiation is necessary, stereotactic radiotherapy is the normal course of action, says Ibrahim Aref, MD, Medical Director of Radiation Oncology. For early stage patients who are not candidates for surgery, these high dose, precisely targeted treatments work well. Generally four doses are administered over just two weeks.

"Outcomes are excellent," notes Dr. Aref. "We are seeing 80 to 85 percent of patients with five-year survival rates for single site cancers. Even if the cancer has spread within the lung, we can still treat it. While 20 years ago, the five-year survival rate for metastatic cancer would have been in the single digits, now it is significantly improved. We are able to slow down the progression of the disease."

Caring for the whole patient

The Cancer Institute provides numerous educational and support programs for patients and families including:

- Reiki and massage therapy by oncology certified practitioners
- Nutrition counseling
- American Cancer Institute programs
- Support groups
- Specialized physical and occupational therapy to help patients regain strength.

In addition, Dr. Henderson notes that survivorship care planning is a must with more and more people surviving cancer. The plan is a way to help them thrive.

"The medical oncologist works hand in hand with the primary care physician (PCP) with the idea to transition the care back to the PCP," Dr. Henderson said. "Curing cancer affects patients in unique ways so we need to be prepared for that and give them the tools and information they need."

St. John Macomb Oakland Hospital

CARLOS RAMIREZ, MD NAMED TO D-BUSINESS MAGAZINE'S 30 IN THEIR 30S

Carlos Ramirez, MD, director, Lakeshore Center for Head and Neck, Maxillofacial & Reconstructive Surgery, was named one of D-Business Magazine's 30 in their 30s. Dr. Ramirez established St. John Providence Health System's specialized microvascular surgery program that provides reconstruction surgical options to head and neck cancer patients, patients with maxillofacial trauma or those with soft/hard tissue defect.

ST. JOHN MACOMB-OAKLAND HOSPITAL OPENS NEW OB TRIAGE UNIT

St. John Macomb-Oakland celebrated the opening of its new OB triage unit at the Macomb Center in Warren. Construction of the space began in the spring and the upgraded space is more spacious, provides greater privacy for patients, and includes an additional bay and restroom. There is also easier access to the delivery room in an event of an emergency.

VISITING JAPANESE CARDIOLOGIST SHARES EXPERTISE ON TRANSRADIAL CORONARY INTERVENTION

St. John Hospital and Medical Center recently hosted Takaski Matsukage, MD, PhD, FAPSIC, an interventional cardiologist and chief director of ICU/CCU at Tokai University Hachioji Hospital in Tokyo, Japan. During his three-day visit, Dr. Matsukage shared his unique and in-depth experience and wisdom of transradial coronary intervention, including proctoring a few complex coronary interventions cases in the St. John Hospital and Medical Center cardiac catheterization lab and presenting during the Cardiology Grand Rounds.

STATE OFFICIALS DISCUSS EBOLA PREPAREDNESS WITH HOSPITALS

The Michigan Health & Hospital Association took part in a roundtable event held recently by state officials to discuss Michigan's efforts to prepare for Ebola should a case develop in Michigan. Infectious disease experts met with U.S. Rep. Gary Peters and representatives from Sen. Carl Levin's and Sen. Debbie Stabenow's offices to learn about Ebola preparedness and discuss how the federal government can support Michigan hospitals in their efforts.

Cathy Barwick, RN, SJMOH director of nursing, U.S. Rep. Gary Peters and infectious disease specialists from Michigan hospitals discuss emergency preparedness.

RENOWNED NURSE THEORIST MEETS WITH ST. JOHN HOSPITAL AND MEDICAL CENTER NURSES

Nurses from St. John Hospital and Medical Center had the unique opportunity to meet with renowned nurse theorist Jean Watson, the founder of The Watson Caring Science Institute, an international non-profit foundation created to advance the philosophies, theories and practices of Human Caring Science. About 40 nurses shared how they are integrating Human Caring practices into their daily work, as well as the challenges and success that have resulted. Jean's visit was part of the 20th annual International Caring Science Consortium, a two-day interactive and collaborative professional practice gathering that brought together individuals from around the

world who are actively engaged in applying Caring Science and the Theory of Human Caring. St. John Hospital and Medical Center was the sponsor of the consortium which was held in Dearborn. St. John Hospital and Medical Center Nursing Site Lead Gayle Novack said the highlight of Dr. Watson's visit was the dialogue with direct-care nurses. "Their stories describing the application of nursing theory to care delivery confirmed that our nurses truly understand nursing as a science and an art. They incorporate it into the many tasks they have to complete, going beyond tasks to caring that supports healing at the bedside. We are extremely fortunate to have such knowledgeable and engaged nurses in our midst."

ST. JOHN HOSPITAL AND MEDICAL CENTER AWARDED PERFECT CENTER OF EXCELLENCE REACCREDITATION FOR BARIATRIC SURGERY

St. John Hospital and Medical Center recently underwent the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) reaccreditation process to continue to remain a Center of Excellence for bariatric surgery. The site was awarded the full MBSAQIP reaccreditation without any corrections necessary.

NEW LEADERSHIP FOR ST. JOHN HOSPITAL AND MEDICAL CENTER TRANSPLANT PROGRAM

Transplant Surgeon Darla Granger, MD, has been promoted to director of the Transplant Specialty Center at St. John Hospital & Medical Center. Dr. Granger has been with the transplant program since 2004. Transplant Nephrologist David Butcher, MD, has been promoted to medical director of the Transplant Specialty Center. Dr. Butcher joined the transplant team in 2006.

Darla Granger, MD Director, Transplant Specialty Center , St. John Hospital and Medical Center

David Butcher, MD Medical Director, Transplant Specialty Center, St. John Hospital and Medical Center

ST. JOHN PROVIDENCE HEALTH SYSTEM EAST REGION PHARMACY DIRECTOR NAMED PHARMACIST OF THE YEAR

Gary Blake, director of pharmacy for St. John Providence Health System east region, was named the 2014 Michigan Society of Health-System Pharmacists (MSHP) Pharmacist of the Year at the Society's Annual Meeting on Nov. 7. As director, Gary oversees pharmacy services for the three east region hospitals, as well as represents pharmacy practice and the Michigan Region in several roles with Ascension Health. During the award ceremony, the MSHP noted Gary's distinguished career, and his leadership in a variety of areas of pharmacy practice, including pharmacy services in a large integrated health system; inpatient pharmacy operations; clinical pharmacy practice; pharmacy information systems and technology; long-term care; leadership development, financial management; and program development.

ST. JOHN HOSPITAL AND MEDICAL CENTER TRANSPLANT PROGRAM DIRECTOR RETIRES

Henry K. Oh, MD, director of transplant services retired in September, after 24 years of service at St. John Hospital & Medical Center. Dr. Oh was instrumental in building the hospital's transplant program. Here are some highlights from his impressive career:

- Since 1990, more than 1,200 transplants have been performed.
- First in the state to perform a non-directed living donor kidney transplant; this led the creation of the national program, the "Never-Ending Altruistic Donor" (NEAD) chain.
- In 1998, Dr. Oh recruited Dr. Hawasli who performed cutting-edge laparoscopic donor nephrectomy surgery to living donors (first in Michigan); since then more than 350 laparoscopic donor nephrectomies have been performed at St. John Hospital and Medical Center.
- Pioneer in cutting-edge immunosuppression therapy, length of stay and ground-breaking transplant procedures.

CODE BREAKING, COMPUTERS AND MAGIC

By: Adrian J. Christie, MD
Editor, Macomb Medicus

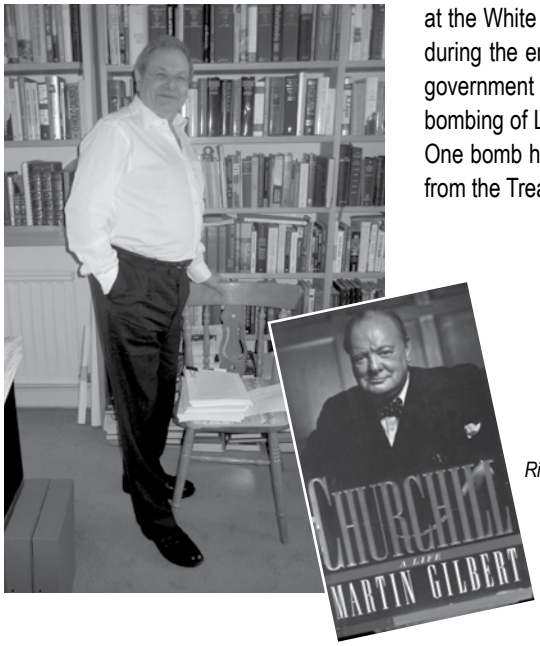
WW1 POEM BY LIEUTENANT COLONEL JOHN MCCRAE, MD (1872-1918), CANADIAN ARMY

In Flanders Fields the poppies blow
Between the crosses row on row,
That mark our place; and in the sky
The larks, still bravely singing, fly
Scarce heard amid the guns below.
We are the Dead, Short days ago
We lived, felt dawn, saw sunset glow,
Loved and were loved, and now we lie
In Flanders fields
Take up our quarrel with the foe:
To you from falling hands we throw
The torch; be yours to hold it high,
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields.

This passing year of 2014 is notable for marking the centennial of the outbreak of World War 1, commemorated in this country and throughout Europe by services at numerous cemeteries and burial sites. Modern technology has even allowed closure on deaths of relatives, mostly young men at that time long ago, whose body remains are now being identified by DNA analysis.

I was an infant and small child during World War 2, which some historians consider a continuation of WW1, also known as "The Great War" or "The War to End all Wars" as it was called at the time. However, I do have memories of sleeping in a brick and concrete air raid shelter in our back garden. In the 1990's, curiosity took me to that house in Cardiff, Wales, where the then current owner informed me that they had only just recently had that shelter demolished. The more I look back on those fateful years when for a critical period Britain stood alone against the onrush of Hitler's Germany through Europe, the more I have learned that a convergence of leadership, brains, courage and resolve of unprecedented proportions, characterized emblematically by Winston Churchill but assisted by a team effort of the British people, and later those of the USA, enabled civilization as we still recognize it to triumph over the barbarous Third Reich. There were so many things that did, and could have gone wrong in that war resulting in a very different outcome. As we now know, but not everyone did then, Hitler had other plans for Jewish children and their families.

I learned firsthand about Churchill's courage from his official biographer, the historian Sir Martin Gilbert, who my wife and I befriended more than 25 years ago when he visited Detroit. In 2011, he gave us an unofficial tour around Whitehall where he pointed out government offices where he worked as one of five members of the "Iraq Commission" reviewing documents anteceding the invasion of Iraq (to determine if the Blair government misled the country). He also showed us where Churchill resided during the war. Many tourists have visited an underground "Churchill Museum" where furnishings, phones, posters and military charts have been "frozen" since war's end, with a small bed where the Prime Minister was said to have slept. There is a special phone which was directly linked to Roosevelt at the White House. Martin, as we called him, said that the great man slept there for just two nights during the entire war. He refused to 'live like a rat', as he put it, but chose a room in the strongest government building, the Treasury, where he often went to a high lookout site at night to view the bombing of London. The whole city was on fire during the Blitz and many thousands of people died. One bomb hit an underground subway station acting as an air raid shelter just a few hundred yards from the Treasury, claiming dozens of lives.



Far left: Martin Gilbert in his library.

Left: Martin Gilbert's biography on Winston Churchill

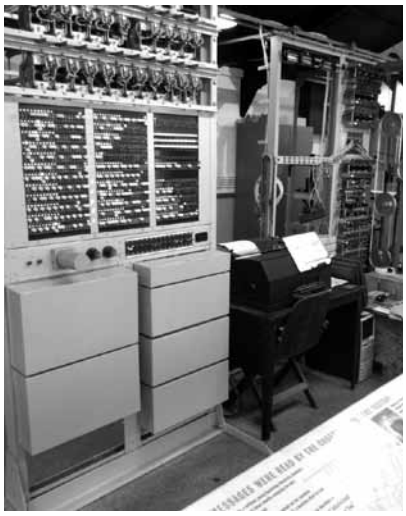
Right: Whitehall Treasury Building where Churchill resided during WWII

CODE BREAKING, COMPUTERS AND MAGIC

Far right: Bletchley House

Right: Enigma machine

Below: Bombe rebuild



Above: Colossus computer

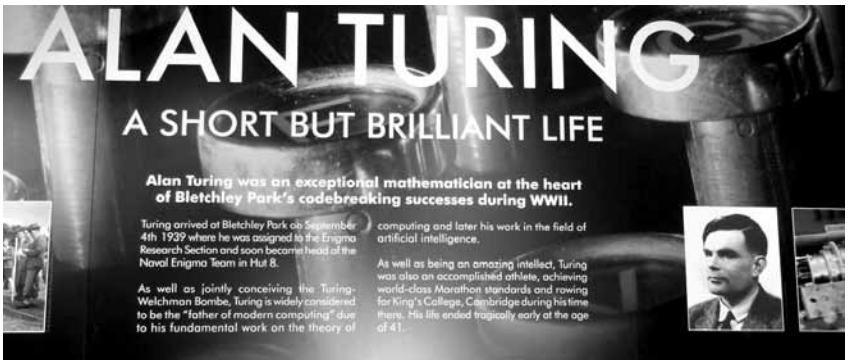
Winston Spencer Churchill was born in 1874 in the mid-Victorian era. His ancestry was a good predicator of his war time leadership. On his father's side he was born into British aristocracy, descended both from the first Earl Spencer and from the distinguished soldier John Churchill, first Duke of Marlborough who led a coalition of armies at the beginning of the 18th century to defeat the French. His mother, Lady Randolph, was entirely American, the daughter of Leonard Jerome, then in New York, a stockbroker, financier and newspaper proprietor, whose ancestors were men who had fought with George Washington in the colonial wars of Independence.

Churchill became a member of parliament just shy of his 26th birthday and was appointed to government positions in the early 1900's including Home Secretary and First Lord of the Admiralty. He was forced to resign from the Admiralty in the First World War after presiding over a military disaster, the Gallipoli campaign, which resulted in great loss of life. As Home secretary and in charge of the police in the interwar years, he helped to suppress a General Strike and became hated by large numbers of the working class, not least the Welsh miners who marched at the time for "living wages". In the 1930's, he was considered a warmonger and a pariah by much of the journalistic and ruling establishment, since he publicly warned about the dangers of German rearmament. What we now call "appeasement" was very popular in a country which had lost a major proportion of its young men in the carnage of WW1 and was top-heavy with widows and bereaved parents. When Hitler invaded Poland in 1939, Prime Minister Chamberlain wisely invited him into the government. Churchill was then 65, at an age when so many people retire from work.

Britain with its overseas allies and later the United States came very close on many occasions to losing WW2. Churchill's leadership was critical. It helped that Hitler made bad military decisions. His determination to achieve air superiority before invading Britain was confounded by invention of radar and the brave pilots of the RAF during 'The Battle of Britain'; few of them, mostly kids barely out of school, made it through the war. His diversion of air power to massive bombing of London in retaliation for air attacks on Berlin gave a critical respite to the RAF, whose airfields had almost all been destroyed by German air raids at that time. When he decided to invade Russia in 1942, my parents presciently named my brother, born at that time, Victor in anticipation of a British victory. Britain was almost starved into submission in 1941 and '42 during the Battle of the Atlantic when U-boat submarines were sinking millions of tons of shipping sent in convoys from Newfoundland carrying food and munitions, drowning thousands of seamen and civilians. During the first eight months of 1942, over 4 million tons of shipping were sunk by U-boats, between sixty and 108 ships every month. It took a herculean effort of code breaking by a large team

Right: Alan Turing poster

Far right: Bletchley staff c. 1945



of mathematicians, scientists and dozens of young women assembled at a country manor outside London called Bletchley to break the German codes enabling the ships to avoid the submarines and allowing Britain to fight on. I spent a day at the museum now called Bletchley Park in October 2014. Much of the code-breaking took place in various designated huts around the estate. For instance, Hut 4 was where naval codes were deciphered and Hut 6 housed the Air Force Enigma code breaking unit. Employees, sworn to secrecy, even after war's end, usually lived off the grounds in surrounding villages. The big house had offices of chief code breakers including the brilliant Alan Turing whose genius proved essential to the whole enterprise. One code-breaking machine designed by Turing and named a "Bombe" was built in large numbers on both sides of the Atlantic. I discovered that the very first computer using digital data was assembled at Bletchley, and we all know how this invention has transformed our lives, not least in the medical field. Named "Colossus", it made a critical contribution to the war effort by deciphering German teleprinter codes. Recording data on magnetic tape had not yet been invented and paper tape with thousands of punched holes was being used. This machine had been built by telephone engineers, and volunteers from British companies including Ford UK undertook a project in recent years to reassemble it, where it is now displayed in working condition at the museum. Thanks to an American investigative reporter, Edwin Black, we now know that the Germans were using IBM tabulating equipment with similar paper tapes supplied from the USA in the early 1940's to organize the Holocaust, but that is another story.

Deception also played an important role in defeating the Germans. Hundreds of fake tanks and military vehicles were assembled across the water from Calais prior to the D-Day invasion which took place further north in Normandy. Fake Enigma messages were sent from Britain to a Spanish agent in France to fool the enemy about the planned landing sites. The Germans expected the Allies would likely take the shortest sea crossing for the invasion, a preconception successfully reinforced by these deceptions.

The art of deception, used by magicians and war time planners, was summarized by the famous American magician, David Blaine, in Detroit recently for a charity fund-raising event. He wrote in the Economist magazine 2015 year end publication, "One of the wonderful things about the art of magic is that it doesn't really matter where the trap door is. This is not the secret. The secret is that magicians influence what you think by using your own preconceived ideas of the world around you to amaze you. We realize that you will think your own experience while watching magic is unique to you, but we know that, in general, everyone thinks in more or less the same way. Even as it gets harder to have a technological edge, applying this psychological edge offers us nearly limitless possibilities. Much of the secret innovation behind magic will not appear on YouTube. It comes from endless hours of trial and error in an effort to understand our audience".

This recent visit to the UK in October 2014 was highlighted by a reported medical milestone. Though not magic, the patient may have considered it so. He was a spinal injury victim who had been rendered paraplegic. Following a tissue transplant undertaken by British and Polish doctors he recovered sufficient function to walk once again!

References:

McCrae's "In Flanders Fields" remains to this day one of the most memorable war poems ever written. It is a lasting legacy of the terrible battle in the Ypres salient in the spring of 1915. Although he had been a doctor for years and had served in the South African War, it was impossible to get used to the suffering, the screams, and the blood here, and Major John McCrae had seen and heard enough here to last him a lifetime. As a surgeon attached to the 1st Field Artillery Brigade, Major McCrae, who had joined the McGill faculty in 1900 after graduating from the University of Toronto, had spent seventeen days treating injured men- Canadians, British, Indians, French, and Germans- in the Ypres salient. He wrote it shortly after a young friend and former student, Lieut. Alexis Helmer of Ottowa, had been killed by a shell burst on 2 May, 1915, and he had performed the funeral ceremony in the absence of the chaplain. In fact, it was very nearly not published. Dissatisfied with it, McCrae tossed the poem away, but a fellow officer retrieved it and sent it to newspapers in England. The Spectator in London rejected it, but Punch published it on 8 December 1915.

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http://www.economist.com/world-in-2015-app http://davidblaine.com/video

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Paralyzed man walks again - and the answer was under his nose: http://www.telegraph.co.uk/health/healthnews/11178022/Paralysed-man-walks-again-and-the-answer-was-under-his-nose.html


THE TIMES

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THE DAILY FOOD LIST 4-PAGE PULLOUT

How Timothy Spall learnt to paint like Turner Times2

Paralysed man walks again

Historic breakthrough funded by campaigning father after son disabled in swimming accident

Dieter Wendling, MD
1928 - 2014

Dieter Wendling, MD, DDS, of Manistique, Michigan, passed away at Meadowbrook Medical Care Facility in Bellaire, Michigan, on September 21, 2014. Dr. Wendling was born on July 8, 1928, in Mainz, Germany, where he studied dentistry and medicine, obtaining his doctorate degrees in both fields. He immigrated to the United States in 1954, settling in Bloomfield Hills, Michigan.

Dr. Wendling performed his medical residency at Harper Hospital in Detroit, Michigan, after which he went into private practice in Southfield, Michigan in the specialty of otolaryngology. He was on the surgical staff at Beaumont Hospital in Royal Oak, Michigan, where he became chief of staff in otolaryngology, specializing in head and neck surgery and microsurgery of the ear. He also served as adjunct professor at Wayne State University in Detroit.

In 1976, Dr. Wendling moved his practice to Mt. Clemens, Michigan, where he joined the surgical staff of St. Joseph's East and West Hospitals before retiring in 1989 and moving to Manistique, Michigan, to enjoy his Lake Michigan home.

Dr. Wendling also joined the U.S. Army Reserves where, after twelve years, he rose to the rank of lieutenant colonel. During his medical career, he performed numerous surgeries for charity and treated patients at the state hospitals in Newberry and Pontiac, Michigan.

In 1953, Dr. Wendling married Monica Rice, who preceded him in death. In 1963, he married Eva (Braun), who survives him. Dr. Wendling is survived by his sisters, Ursula Zitzelsberger, Klara Schneider, Dr. Anna Marie Schaefer, and his brother, Dr. Peter Wendling. His brother, Dr. Claus Wendling, preceded him in death. Dr. Wendling is also survived by his children, Alexander (Ted) Wendling of Bexley, Ohio; Dr. Karen Wendling of Guelph, Ontario, Canada; Tanya Wendling of Santa Cruz, California; Barbara Wendling of Rochester Hills, Michigan; and Peter Wendling of Bellaire, Michigan. He is also survived by his step-children, Andre Rachmaninoff of Bradenton, Florida, and Jean-Pierre Rachmaninoff of Nashville, Tennessee. His step-daughter, Michelle Rachmaninoff, preceded him in death. Dr. Wendling is also survived by his children's and step-children's various spouses, as well as by numerous grandchildren.

He will be greatly missed. In lieu of flowers, memorial donations may be made to St. Luke the Evangelist Catholic Church, P.O. Box 799, Bellaire, Michigan, 49615.

Arrangements have been handled by the Bellaire Chapel of Mortensen Funeral Homes.

Donald G. Blain, MD
1924 - 2014

Donald G. Blain, MD, FACS, of St. Clair Shores, Mich., born 1924, died May 20, 2014. His parents were Dr. and Mrs. Alexander W. Blain of Grosse Pointe. Dr. Alexander W. Blain founded the Blain Clinic in 1911 and the Alexander Blain (Teaching) Hospital in 1924 which had complete residencies in general surgery and internal medicine. He was Professor of Clinical Surgery at Wayne. The hospital was named after his father who joined the Union Army in Detroit as a sharp shooter later becoming head of the Detroit Department of Parks and Boulevards and Elmwood Cemetery.

Don married Grace Carpenter in 1955, Honor Student and Valedictorian of her Class at Frederick, Maryland High School, and also graduated from the Church Home Hospital School of Nursing in Baltimore. She was a horsewoman and civic leader, who survives him along with son Ian Donald (Donna) Blain and daughters Elizabeth Ann Johnson (Charles, JR.) and Patricia Droneberg Blain, and grandson Eric Johnson. They lived on Balfour and Lake Court in Grosse Pointe, Jefferson in St. Clair Shores, and Blain Island, Waterford, Mich. as well as Lewistown, Montana, and Cody, Wyoming.

Don attended the Detroit University School (now University Liggett), The Hill School, Princeton, Wayne Medical School, and taught at Wake Forest Medical School and was also on the faculty of Northwest College in Powell, Wyoming. He served as Captain, US Air Force, Medical Officer to the 121st Fighter Squadron during the Korean War. He was Assistant Director of the Alexander Blain Hospital.

He became President of the Macomb County Medical Society, also the Michigan Branch of the American Urological Association, and founded the Oakland Macomb County Professional Standards Review Organization representing all their doctors for quality

in medicine. He was the Admissions Chairman of the American Association of Clinical Urologists. He was one of six Urologists in Michigan in the International Society of Urology in 1985. He lectured in the US, Europe, and South America.

He belonged to the Alpine Club in Westcliffe, Colorado, the Detroit Club, the Detroit Racquet Club, the Grosse Pointe Hunt Club (board), the Country Club of Detroit, the Metamora Hunt, The Metamora Club, the Princeton Clubs of Michigan and New York, and the Sedgefield Hunt in Greensboro, North Carolina, and the Annapolis Roads Club in Maryland, He was President of the Detroit Science Museum Society (to bring a Natural Science Museum to Detroit).

He served on the Boards of the Alexander Blain Hospital, West Park Hospital in Cody, WY, the Detroit Surgical Association, the Grosse Pointe Hunt Club, the Michigan Doctors Political Action Committee (Secretary Treasurer), the University Liggett School Alumni Board, the St. Andrews Society, the Grosse Pointe Senior Men's Club (of 800), Historian, and the Grosse Pointe Rotary Foundation- President.

In the West, he was President of Rotary in Lewistown, Montana. He reviewed Montana hospitals for Continuing Medical Education Accreditation. In Wyoming, he served on the Boards of the West Park Hospital, the Wyoming Center for the Book, the Park County Libraries, the Cody Chamber of Commerce, the Park County Yellowstone Regional Airport, and was appointed to the State of Wyoming Workman's Compensation Medical Commission, working until 2004. He was appointed Vice Chairman the Park County Republican Committee and, for six years, was Commander of the American Legion in Cody. While there, he was Treasurer of the National Coalition against Legalized Gambling and a registered lobbyist which kept commercial gambling out of Wyoming.

St. Joseph Hospital (Now Ford) in Mount Clemens gave him the Lifetime Achievement Award. He was also head of Urology for the Henry Ford Hospital Hall Road Satellite. He was an Honorary Life Member of the Nature Conservancy. He was in Who's Who in the Midwest and in Who's Who in Medicine and Health Care. His fraternities were Gamma Delta Psi and Nu Sigma Nu. At 79, he was first in the 25 meter freestyle swim in the State of Wyoming Senior Olympics (class 75-79). He gave the principle address at the 150th Anniversary of the founding of the Union Memorial Hospital in Baltimore. He played Varsity Basketball at age 14. He was an avid Fox Hunter with Horse and Hound (fox not killed) and enjoyed motorcycling, power boating, ice boating, and flying (soloed in 1945), literature, poetry, and photography.

He requested no funeral. His ashes will be in the family plot in Elmwood Cemetery, Detroit. Any remembrance may be made to a local Humane Society.

ANNOUNCEMENTS

JANUARY 28 MSMS "Compliance Essentials You Need to Know in 2015", Detroit Marriott Troy, in Troy, 9 am - 3:30 pm. To register visit www.msms.org/Education or call 517-336-7581.

FEBRUARY 17 MSMS "Beyond Checking the Box: Legalities and Practicalities of HIT", Detroit Marriott Troy, in Troy, 9 am - 3:30 pm. To register visit www.msms.org/Education or call 517-336-7581.

MARCH 4 MSMS "PCMH: Supporting Patients through Population Health", Detroit Marriott Troy, in Troy, 9 am - 3:30 pm. To register visit www.msms.org/Education or call 517-336-7581.

MAY 2 - 3 MSMS House of Delegates, Amway Grand Plaza in Grand Rapids.

Watch for emails and fliers with the details of upcoming events.

Does the MCMS have your email address? If not, send it to us at mcms@msms.org or call 810-387-0364 so that we can keep you informed!
Change of Address? Let us know! Call 810-387-0364 or Email us mcms@msms.org any changes.

SGR, EBOLA, MOC, AND UNIONIZATION DISCUSSED AT AMA INTERIM MEETING

The Michigan Delegation to the AMA House of Delegates discussed, debated, and acted upon on a number of critical health care issues during the AMA Interim meeting on Nov. 7-11 in Dallas.

Some of the topics included SGR repeal, Ebola, meaningful use, maintenance of certification, e-cigarettes, and physician unionization.

Serving at the AMA Interim Meeting from the Michigan Delegation were Betty Chu, MD, MBA, from Oakland County, and Bassam Nasr, MD, MBA, from St. Clair County, both of whom served on the Reference Committee F regarding AMA finances. John Bizon, MD, served as a teller.

Hot topics at the AMA Interim Meeting included the following.

SGR REPEAL: The AMA's lead lobbyist and two U.S. Congressmen told the House of Delegates that repealing and replacing the flawed Sustainable Growth Rate formula in this fall's lame duck session of Congress is the best opportunity for a fix. Texas Congressman Michael Burgess, MD, said "we are in extra innings," but there remains bipartisan, bicameral support to fix the SGR. His fellow Texas Congressman Kevin Brady said the difficulty remains the "pay fors," in other words, what will be cut in the budget to pay for the $150 billion fix. AMA lead lobbyist Richard Deem said Michigan Congressmen Fred Upton and David Camp have pushed the legislation to the point that "we are closer than ever." However, he noted that "legislation is the art of compromise, but this (fix) is a clear improvement over current law." He said a "patch 18" would be unacceptable to the AMA. Deem also noted that the AMA will work to repeal the Independent Payment Advisory Board in the next legislative session.

EBOLA: A leading expert on Ebola from the CDC told the House of Delegates in a special two-hour educational session that "ultimately, the best way to protect the U.S. is to stop the outbreak in Africa." Details about diagnosing and treating patients as well as protecting health care workers were provided. The House later discussed four resolutions regarding Eloba and combined them into one that called for support of global efforts to fight Ebola and other epidemics and pandemics and to work to ensure that quarantine interventions are based on science and not politics or emotion. The House also committed the AMA to being a trusted source for dissemination about all information regarding Ebola on its Ebola Resource Center at www.ama-assn.org. Ebola information is also available on the MSMS website at www.msms.org/ebola.

MEANINGFUL USE: A very popular resolution among delegates about electronic health records called for the AMA "to continue to advocate that the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria." Testimony emphasized the fact that the meaningful use program remains a significant cost and disruption to physicians and that EHRs are not yet capable of exchanging health care information across different systems.

MAINTENANCE OF CERTIFICATION: Four resolutions about various aspects of Maintenance of Certification engendered significant, strong discussion in reference committee and on the floor of the House regarding the balance between the costs and burdens of MOC versus maintaining physician competence and public trust. A combined, substitute resolution was adopted that called for the AMA to add a number of amendments to its current Principles on MOC to use when in discussions with the American Board of Medical Specialties including cost, relevance, and design. Also added was that MOC should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment, as well as to eliminate the practice performance assessment modules. The AMA Council on Medical Education will send a report back to the AMA House of Delegates at the Annual meeting in June 2015.

E-CIGARETTES: Three resolutions were combined with a new report from the AMA Council on Science and Public Health that called on the AMA to support legislation to set 18 as the minimum age for buying and using any e-cigarette product, to prohibit the use in any health care setting, and to apply the same restrictions as those on tobacco for marketing and sales including a prohibition on television advertising.

PHYSICIAN UNIONS: A resolution calling for the AMA to conduct a study about physician unionization was adopted after arguments on both sides of the issue were aired. On the con side, some delegates argued that the only way unions are effective is through work stoppages and that medical ethics outlaws such activity by physicians. On the pro side, the argument was made that the number of employed physicians in all practice settings has increased significantly since the last time the AMA studied this issue in 2001. A new AMA study will be conducted, but a timeframe for reporting back was not immediately set.

10 MEDICARE PAYMENT POLICY REVISIONS YOU NEED TO KNOW

Chances are you haven't been able to read through the nearly 1,200 pages that constitute the 2015 Medicare Physician Fee Schedule final rule released Oct. 31 and published Thursday in the Federal Register. Here are the 10 top payment policy changes discussed in this mammoth

document that you need to know about.

1. The sustainable growth rate (SGR) formula calls for a 21.2 percent cut to physician payments, effective April 1. While this is a steep reduction, it is a considerable drop from the nearly 30 percent cut projected just a few years ago. The reduction is thanks to nearly flat growth in utilization of physician services over the past several years. The AMA continues to press Congress to repeal the SGR formula to eliminate the perennial payment cut threats and temporary legislative patches.

2. Continuing medical education (CME) will not be reported under the Physician Payments Sunshine Act. The Centers for Medicare & Medicaid Services (CMS) proposed including CME activities in reports of physicians' financial interactions with medical device and drug manufacturers in the new "Open Payments" public database. The AMA led dozens of other medical associations in calling on the agency to eliminate this requirement because it would "chill physician participation in independent [continuing education] programs."

3. Proposed penalties under the value-based payment modifier (VBM) will be scaled back. CMS intended to increase payment penalties under the modifier from 2 percent to 4 percent, beginning in 2017. The AMA strongly objected to this proposal, noting in a comment letter on the proposed rule that some physicians would be vulnerable to payment cuts totaling more than 11 percent as a result of the VBM and other Medicare reporting programs—a move that could mean some of Medicare's sickest patients would lose access to their doctors.

While the final rule still maintains a potential pay cut of 4 percent for larger medical groups, practices with fewer than 10 physicians will not be subject to more than a 2 percent VBM penalty.

4. The Physician Quality Reporting System (PQRS) becomes a penalty-only program next year. Physicians must successfully report in 2015 to avoid PQRS and VBM penalties in 2017. Among other things, they'll have to report on at least nine quality measures that cover three "domains." In addition, the final rule requires physicians to report on at least one of the 18 new "cross-cutting measures."

CMS originally said physicians would be obligated to report on at least two cross-cutting measures but cut that requirement in half after the AMA urged the agency not to create additional mandates that physicians would struggle to meet.

The agency also had planned to shorten the period physicians have to review their feedback reports to just 30 days. Following AMA lobbying, CMS decided to leave the review period at 60 days.

5. The Physician Compare website will continue to expand - but not as much as planned. Continued pressure from the AMA has led CMS to commit to better prevention and correction of errors on this website that has been riddled with problems. The agency also will notify physicians when they can preview their reports.

While the agency's plans to post benchmarks to the site have been put aside for now, the website will show physicians' performance under PQRS, the electronic health record meaningful use program and Medicare accountable care organizations.

6. Chronic care management services will be supported by a monthly payment. Beginning next year, CMS will pay $40.39 per month for these services when CPT code 99490 is reported. This policy change reflects several years of advocacy by the AMA, the CPT Editorial Panel and the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The groups will continue to urge the agency to also adopt higher values and pay for multiple complex chronic care coordination services so that patients have ongoing access to this important care.

7. Four services now are eligible for telehealth payment. These services are Medicare's annual wellness visit (coded with HCPCS G0438 and G0439), prolonged evaluation and management services (reported with CPT codes 99354 and 99355), family psychotherapy (CPT codes 90846 and 90847) and psychoanalysis (CPT code 90845).

8. Surgical global periods will change from 10- and 90-day periods to 0-day periods. Despite strong opposition from the AMA and many medical specialty societies, CMS will be transitioning all services with a 10-day global period to a 0-day global period by 2017. All 90-day global periods will be shifted to 0-day global periods by 2018.

9. There are 350 CPT codes identified as new, revised or potentially misvalued - 318 of these changes were based on physician input. These changes represent 86 percent of those recommended by the RUC, a group of more than 300 participants that includes physician advisers from every medical specialty and a dozen other health care professionals. The group provides input on values based on their highly technical expertise.

10. The timeline for submitting new codes and revaluations of services will shift. The deadline for receiving all code and value recommendations for the following year's payment policies will be February to allow more time for public comment. This change will take place for the 2017 Medicare Physician Fee Schedule. CPT and RUC timelines will be modified to accommodate the new process, thereby ensuring physicians continue to have strong input on appropriate values for services.

You can read more about these and other components of next year's Medicare payment policies by downloading an AMA summary at www.ama-assn.org/resources or viewing fact sheets from CMS at www.cms.com/newsroom.

SHARE YOUR NEWSWORTHY ITEMS

Have you or a MCMS colleague been elected to a position (specialty society, hospital, community based program, etc.) or honored for your volunteer service within the community or abroad? Let us know. We would like to recognize MCMS members in the 'Member News' section of the Medicus.

Contact Heidi Leach at mcms@msms.org or macombcms@gmail.com with newsworthy information.

Publication is subject to availability of space and the discretion of the Editor.

Thanks to Your Generosity the 2014 Holiday Sharing Card Project Raised $6,200

We would like to thank the MCMS members who participated in the 2014 MCMS Foundation Holiday Sharing Card Project. Due to your generous donations we were able to raise $2,735 for the Macomb County Food Program and $3,465 for Turning Point Shelter for women.

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Need insurance, looking to refer a patient?

Look to the physicians and companies who advertise in the Medicus.

Macomb County Health Department Reportable Diseases Summary
Diseases Reported - Note: Cumulative total for previous years; year-to-date for NOVEMBER 2014

	2014	2013	2012
AIDS	46	35	44
AMEBIASIS	1	1	0
BLASTOMYCOSIS	1	0	0
BOTULISM (FOODBORNE)	0	0	0
BOTULISM (INFECTIOUS)	0	0	0
BRUCELLOSIS	0	0	0
CAMPYLOBACTER	78	68**	118**
CHICKENPOX	82	40**	46**
CHLAMYDIA	2,164	2,514	2,393
COCCIDIOIDOMYCOSIS	7	2	2
CREUTZFELDT JAKOB	2	1	0
CRYPTOCOCCOSIS	2	1	6
CRYPTOSPORIDIOSIS	8	7	2
DENGUE FEVER	0	0	1
DIPHTHERIA	0	0	0
EHRLICHIOSIS	1	0	0
ENCEPHALITIS PRIMARY	3	0	8
ENC POST OTHER	2	2	3
E. COLI 0157	***	***	***
FLU-LIKE DISEASE	22,403	42,989	36,172
GIARDIASIS	18	19	24
GONORRHEA	440	575	530
GRANULOMA INGUINALE	0	0	0
GUILLAIN-BARRE SYNDROME	6	8**	5**
HEMOLYTIC UREMIC SYN.	0	0	0
HEPATITIS A	3	7	1
HEPATITIS B (ACUTE)	7	7	4
HEPATITIS B (CHRONIC)	129	123**	152**
HEPATITIS C (ACUTE)	12	7	6
HEPATITIS C (CHRONIC)	627	494**	598**
HEPATITIS D	0	0	1
HEPATITIS E	0	0	3
H. FLU INVASIVE DISEASE	9	11	8
HISTOPLASMOSIS	2	3**	7**
INFLUENZA, NOVEL	0	0	0
KAWASAKI SYNDROME	5	9	6
LEGIONNAIRE'S DISEASE	21	31	15
LISTERIOSIS	1	1	1
LYME DISEASE	1	0	0
MALARIA	1	0	4
MEASLES	0	0	0
MENINGITIS VIRAL	41	75**	75**
MENINGITIS BACTERIAL/BACTEREMIA (EXCLUDING N. MENINGITIDIS)	6	4	6
MENINGOCOCCAL DISEASE	1	0	0
MUMPS	1	0	0
PERTUSSIS	76	108**	30**
POLIO	0	0	0
PSITTACOSIS	0	0	0
Q FEVER	0	1	0
RABIES ANIMAL	3	2	2
RABIES HUMAN	0	0	0
REYE SYNDROME	0	0	0
ROCKY MNTN SPOTTED FVR	0	0	0
RUBELLA	0	0	0
SALMONELLOSIS	68	76**	95
SHIGELLOSIS	8	4	10
STEC***	12	6	6
STREP INVASIVE DISEASE	22	18	9
STREP PNEUMO INV DS	40	58	41
SYPHILIS	29	78	55
SYPHILIS CONGENITAL	0	1	3
TETANUS	0	0	0
TOXIC SHOCK SYNDROME	1	2	0
TUBERCULOSIS	7	11	9
TULAREMIA	0	0	0
TYPHOID FEVER	1	0	0
VIBRIOSIS	0	0	0
VISA	2	2	0
WEST NILE VIRUS	0	3**	28**
YERSINIA ENTERITIS	3	0	0

All 2013 numbers are final

**REFLECTS BOTH PROBABLE & CONFIRMED CASE REPORTS

***New category of Shiga-toxin producing Escherichia coli per MDCH in 2010; combo of E. coli & Shiga Toxin 1 or 2

January/February 2015
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