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MSMS President-Elect Cheryl Gibson Fountain, MD and outgoing MCMS President Lawrence Handler, MD

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Macomb Medicus

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All material for publication, including advertisements, must reach the Society office no later than the 5th (business) day of the month preceding the date of issue, e.g. December 5 for the January/February issue. Thank you.

DECEMBER 7, 2016

MCMS ANNUAL MEMBERSHIP MEETING

The Macomb County Medical Society held its Annual Meeting on Wednesday, December 7 at Ike's Restaurant in Sterling Heights.

Our guest speaker was Michigan State Medical Society President-Elect Cheryl Gibson Fountain, MD, FACOG.

Dr. Gibson Fountain, a Grosse Pointe Park OB/GYN, is Associate Professor of Obstetrics and Gynecology at Oakland University-William Beaumont School of Medicine and attending physician at Beaumont Health Systems, Grosse Pointe/Royal Oak and St. John Hospital & Medical Center.

Dr. Gibson Fountain gave members an in-depth update on MSMS' recent activities. She also led a fantastic discussion of what members need to do in order to prepare for transition to the Medicare Access and CHIP Reauthorization Act (MACRA), which is the law that replaced the SGR and created a new payment framework known as the Quality Payment Program (QPP). Dr. Gibson Fountain also explained that as of January 1, 2017 the QPP will offer two pathways for payment, the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

Following Dr. Gibson Fountain's presentation, MSMS 15th District Director Adrian Christie, MD presented a plaque of appreciation to outgoing MCMS President Lawrence Handler, MD for his service to the society this past year.

MICHIGAN DELEGATION CHAMPIONS MSMS RESOLUTIONS AT AMA

By: Adrian J. Christie, MD; Betty S. Chu, MD; Donald R. Peven, MD;

Your Michigan Delegation to the American Medical Association, led by Chair James D. Grant, MD, MBA, concluded another successful AMA Interim meeting in Orlando in November.

Of the 11 Michigan resolutions submitted, 10 were adopted or adopted as amended. Once again, Michigan's resolutions, which garnered widespread support, dealt with a number of timely issues including those that impact the ability to practice medicine and patient and public safety. Highlights include:

- Continued advocacy for the AMA to increase its efforts to ensure that Maintenance of Certification does not become a mandatory requirement for insurance panel participation, state licensure, or privileging.
- Encouraging the AMA to work with stakeholders to explore alternative evidence-based methods of determining ongoing clinical competency.
- Calling upon the AMA to formally endorse the recommendations contained within the publication, "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association."
- Encouraging the Centers for Medicare and Medicaid Services to develop payment mechanisms that optimize patient access to and utilization of appropriate hospice and palliative care.
- Addressing the health and environmental consequences of using pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH), by banning the use of such materials that contain more than minimal PAH.

"Members of the Michigan Delegation worked hard to support these resolutions," Doctor Grant said. "I'm proud of their dedication and efforts at the Interim meeting."

Not surprisingly, the AMA Interim meeting was abuzz with speculation on the potential impact of the recent US elections on health care and the Affordable Care Act. As a result, policy was adopted directing the AMA to actively engage with the new Administration and Congress, collaborate with state and specialty medical societies, and craft a strong statement reaffirming its commitment to health care reform that improves access to care for all patients.

In light of this action, AMA President Andrew W. Gurman, MD, released a public statement which included the following remarks:

"Using a comprehensive policy framework that has been refined over the past two decades, the AMA will actively engage the incoming Trump Administration and Congress in discussions on the future direction of health care. The AMA remains committed to improving health insurance coverage so that patients receive timely, high quality care, preventive services, medications and other necessary treatments."

"A core principle is that any new reform proposal should not cause individuals currently covered to become uninsured. We will also advance recommendations to support the delivery of high quality patient care. Policymakers have a notable opportunity to also reduce excessive regulatory burdens that diminish physicians' time devoted to patient care and increase costs."

"Health care reform is a journey involving many complex issues and challenges, and the AMA is committed to working with federal and state policymakers to advance reforms to improve the health of the nation."

ARE YOU USING DOCEXCHANGE TO CONNECT WITH COLLEAGUES?

MSMS wants to remind you that DocExchange is live and open to all MSMS members and staff! This collaborative tool provides you with access to networking and educational opportunities, as well as an easy-to-use discussion forum where you may connect, engage and share information and best practices with other MSMS members and staff.

DocExchange is your go-to place to connect, ask advice and share expertise about all things health care or MSMS. You can even share large files without cluttering your inbox!

DocExchange's main discussion group, MEDTalk, is available to all members and staff. Each member already has a customizable profile, so take five minutes to log in and complete your profile and start making connections!

Log in at http://docexchange.msms.org. Your username and password are the same as what you use for the MSMS website. If you're not sure what your login information is, click on the 'Reset Password' link and follow the prompts: https://msms.org/login.

MSMS PRACTICE SOLUTIONS PARTNERS WITH KENT RECORD MANAGEMENT, INC.

In our ongoing effort to bring additional value to your membership, the Michigan State Medical Society Practice Solutions is pleased to announce our latest partnership with Kent Record Management Inc., who provides secure, efficient and innovative record management services. KRM has served the Michigan medical profession for more than 35 years. KRM has four facilities throughout Michigan including Grand Rapids, Lansing, Muskegon and Benton Harbor, which includes the following key areas: shredding, scanning, online backup and recovery, vault media storage, digital preservation and hosted services.

KRM, as our newest partner, will provide a 10% discount on record management services to all MSMS members. To learn more about KRM services, please contact Kevin McFatridge at (517) 336-5745 or email him at kmcfatridge@msms.org.

ALERT: PHISHING EMAIL DISGUISED AS OFFICIAL OCR AUDIT COMMUNICATION

The U.S. Department of Health and Human Services has reported that a phishing email is being circulated on mock HHS Departmental letterhead under the signature of OCR's Director, Jocelyn Samuels. This email appears to be an official government communication, and targets employees of HIPAA covered entities and their business associates.

The email prompts recipients to click a link regarding possible inclusion in the HIPAA Privacy, Security, and Breach Rules Audit Program. The link directs individuals to a non-governmental website marketing a firm's cybersecurity services.

MICHIGAN STATE LOAN REPAYMENT PROGRAM APPLICATION PERIOD STARTS FEB. 1, 2017

The Michigan State Loan Repayment Program 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. 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 compete for consecutive two-year MSLRP loan repayment agreements 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. Providers must remain with the employers who sponsor them during their two-year agreements, and employers must continue to employ the providers they sponsor during their two-year service obligations.

For more information visit the MSLRP website at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_40012---,00.html

Henry Ford Macomb Hospital

HENRY FORD HOSPITALS IN DETROIT, MACOMB COUNTY NAMED TOP 50 CARDIOVASCULAR CENTERS IN THE UNITED STATES

Henry Ford Hospital in Detroit and Henry Ford Macomb Hospital in Clinton Township, have been named Top 50 Heart Hospitals for 2017.

Selected from more than 1,000 hospitals evaluated across the United States, this is the fifth time each of the Henry Ford hospitals have received the award through the 100 Top Hospitals program by Truven Health Analytics.

"We continually strive to provide highly advanced, life-saving cardiovascular options to the people of southeast Michigan," says cardiologist Henry Kim, MD, Division Head for Cardiology in the Edith and Benson Ford Heart & Vascular Institute at Henry Ford Hospital. "To be recognized for that both at Henry Ford Hospital and Henry Ford Macomb Hospital is truly an honor."

The Truven evaluation is based on publicly available data that compares patient outcomes, operational efficiencies and financial metrics. Study winners had better outcomes while operating more efficiently and at a lower cost than others included in the analysis. The Truven data showed 2017 winners had:

- Significantly higher inpatient survival than non-winning cardiovascular hospitals (20% to 55% higher);
- Fewer patients with complications (20-22% fewer);
- Higher 30-day survival rates for acute myocardial infarction, or heart attack; heart failure; and heart bypass patients (.5-1.1% higher survival rate);
- Lower readmissions rates for those same types of patients (1.05 percentage points lower);
- Hospital stays that are on average one day less;
- $1,200 to $6,100 less in total costs per patient case.

Together, Henry Ford Hospital and Henry Ford Macomb Hospital offer cardiovascular options not available at other heart centers in the region, including complex cardiac electrophysiology, advanced cardiac imaging, cardio-oncology and specialists in congenital heart disease.

Henry Ford Hospital in Detroit is a heart magnet hospital for patients throughout Michigan, providing highly specialized care while partnering with cardiologists at patients' local hospitals. The hospital is also the only center in metro Detroit area to offer advanced heart failure treatments ranging from heart pumps to heart transplants, and provides specialized attention through the Henry Ford Women's Heart Center.

The hospital's Center for Structural Heart Disease is home to pioneering interventional cardiologist William W. O'Neill. He is one of only 26 Master Fellows out of 4,500 world-wide members of the Society for Cardiovascular Angiography and Interventions (MSCAI), the professional medical society for invasive and interventional cardiologists. Dr. O'Neill, who pioneered the use of angioplasty to stop heart attacks, and his team continue to perform ground-breaking, catheter-based procedures to treat structural heart disease.

That dedication to advanced care also extends to the award-winning Henry Ford Macomb Hospital in Clinton Township.

The hospital's medical director of cardiothoracic surgery, Steven Harrington, MD, attributes the award to fast, efficient and highly effective treatment for everything from the time it takes to treat a patient experiencing chest pain to the costs associated with cardiovascular care.

From ensuring 100% of patients undergoing angioplasty receive aspirin -- which lowers risk while doctors open blocked or narrowed heart arteries - to low rates of vascular complications and blood transfusions during procedures, the Clinton Township hospital leads the region in cardiac care.

Henry Ford Macomb Hospital offers one of the nation's largest cardiac robotic surgery programs. The hospital also extended cardiology care into the community by providing 12-lead echocardiogram devices to area ambulance providers so cardiovascular specialists can prepare for life-saving interventions during heart attacks while patients are en route to the hospital.

"Our motto, "All for you," isn't just a slogan. It's how we practice medicine, every day," says Dr. Harrington. "We also share our best practices with other health systems, with the thought that we truly focus on improving patient care across the board."

According to industry studies based on Medicare patients, if all cardiovascular providers performed at the level of the Truven winners:

- More than 9,000 additional lives could be saved annually in the United States;
- An additional 6,000 heart patients could be complication-free;
- More than $1.4 billion could be saved.

For more information about the cardiovascular services available through Henry Ford Macomb Hospital or the Henry Ford Heart & Vascular Institute, visit henryford.com/hvi or call 844-725-6424.

ROBOTS ZAP GERMS, PROTECT PATIENTS AT HENRY FORD MACOMB HOSPITAL

They're flashy, but quiet. They work with few breaks and no complaints, tackling a chore that is a top priority at hospitals across the country: preventing hospital acquired infections. They're disinfecting robots, and they add an extra level of infection prevention at Henry Ford Macomb Hospital in Clinton Township and across Henry Ford Health System - the first in metro Detroit to use these bacteria blasters.

Xenex Light Strike™ Germ-Zapping Robots™ are deployed daily, emitting powerful pulses of UV light that quickly destroy

infection-causing bacteria, viruses and superbugs hiding in hard-to-clean places.

At Henry Ford Macomb, two robots - affectionately named Zappy and Violet - disinfect operating rooms, intensive care units and other areas where particularly vulnerable patients are treated, under the guidance of specially trained hospital environmental services employees.

Once humans have finished cleaning the room, the work of the robot begins. The robots run in five or ten-minute cycles depending on the size of the room. The robots work day and night to provide an extra level of sanitization.

The Centers for Disease Control and Prevention estimates that on a typical day, one in every 25 patients in the U.S. has at least one hospital associated infection. These germ-fighting robots are helping to lower that statistic. The robots, which stand about 3.5 feet tall and emit pulsed xenon UV light more intense than sunlight, are effective against the most dangerous pathogens, including Clostridium difficile (C. diff), Methicillin-resistant Staphylococcus aureus (MRSA), VRE, Ebola, norovirus and influenza.

"The robots are a big investment, but the cost is nothing compared to the benefit," said Joanna Pease, DO, Henry Ford Macomb chief medical officer. "We are committed to taking every available precaution to ensure the safety of our patients."

St. John Macomb Oakland Hospital

ST. JOHN PROVIDENCE PARTNERS WITH LAWRENCE TECH ON NEW NURSING SCHOOL

St. John Providence and Lawrence Technological University have received approval from the Michigan Board of Nursing to establish a nursing education program. Scheduled to open next fall, the program will include classroom instruction at LTU's Southfield campus and clinical and laboratory instruction at six SJP hospital locations. Graduates will earn Bachelor of Science degrees in nursing. The program application was approved in early November by the Michigan Board of Nursing. While many nursing programs require two years of prerequisites, the LTU-SJP program will start students in nursing coursework in the first term, making it a unique, attractive option. The new program will admit 32 students annually, and will consist of 126 credit hours over 11 semesters, running year-round. The six St. John Providence locations are Providence-Providence Park Hospital, Southfield and Novi; St. John Hospital & Medical Center, Detroit; St. John Macomb-Oakland Hospital, Warren and Madison Heights; and St. John River District Hospital, East China Township.

ST. JOHN MACOMB-OAKLAND HOSPITAL MEDICAL EDUCATION DIRECTOR BECOMES ACOI FELLOW

Rafael L. Barretto, DO, FACOI, Director of Medical Education, St. John Macomb-Oakland Hospital, was recently made a Fellow of the American College of Osteopathic Internists (ACOI) at the ACOI Annual Convention & Scientific Sessions in Palm Desert, California. Congratulations, Dr. Barretto, pictured center, with SJMOH graduate medical education alumni Peter Francisco, DO (GI), and Jasper Yung, DO (EM/IM).

VETERANS WITH HANDMADE BLANKETS

In honor of Veterans Day, volunteers from St. John Macomb-Oakland Hospital, Warren, donated handmade red, white and blue blankets to inpatients who identified as veterans. SJMOH volunteers Pauline DeFiore-Boesl and Joe Boesl presented US Navy Veteran Rick Krieter, in wheelchair, with a beautiful patriotic blanket handmade by Pauline. Joe, a US Navy veteran himself, discovered in chatting with Rick that they both served on the USS Intrepid! They enjoyed comparing notes while looking at a photo of the historic aircraft carrier. The USS Intrepid launched in 1943 and was used in World War II, surviving five kamikaze attacks and one torpedo strike. It later served in the Cold War and the Vietnam War, and also as a NASA recovery vessel in the 1960s. Decommissioned in 1974, it's berthed today on the Hudson River as the centerpiece of the Intrepid Sea, Air & Space Museum in New York City.

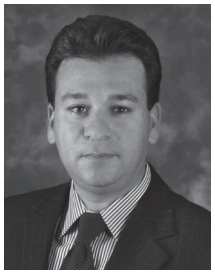
ST. JOHN MACOMB-OAKLAND HOSPITAL EARNS ECHOCARDIOGRAPHY REACCREDITATION BY IAC

St. John Macomb-Oakland Hospital in Warren and Madison Heights has been reaccredited in echocardiography by the Intersocietial Accreditation Commission (IAC). The three-year echocardiography accreditation is in the areas of adult transthoracic and adult stress at both sites. Accreditation by the IAC means that SJMOH has undergone a thorough review of its operational and technical components by a panel of experts. The IAC grants accreditation only to those facilities that are found to be providing quality patient care, in compliance with national

IAC® INTERSOCIETAL ACCREDITATION COMMISSION

standards through a comprehensive application process including detailed case study review. IAC accreditation is a seal of approval that patients can rely on as an indication that a facility has been carefully critiqued on all aspects of its operation considered relevant by medical experts in the field of echocardiography.

SJH&MC APPOINTS SURGICAL ONCOLOGY CHIEF



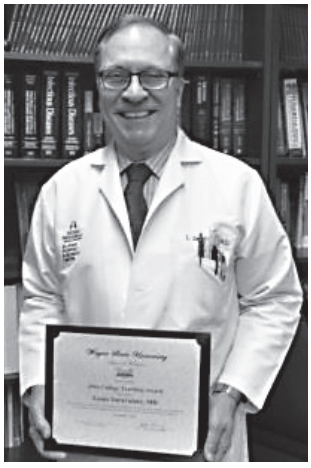
Richard Berri, MD, was recently appointed the new Chief of Surgical Oncology at St. John Hospital & Medical Center. In his new role, Dr. Berri will oversee the Surgical Oncology section under the Department of Surgery. Dr. Berri has been with St. John Providence since 2010. After completing a Surgical Oncology fellowship at the MD Anderson Cancer Center in Houston, Texas, he returned to Michigan. Dr. Berri built the state's first HIPEC Program and also leads the Jerome F. Williams Gastric Cancer program. Dr. Berri's programs, now nationally recognized, treat complex gastrointestinal cancers, including diagnoses of peritoneal carcinomatosis. Dr. Berri is a Clinical Assistant Professor at Wayne State University. He is active in local and national Surgical Associations, and serves on the American College of Surgeons. He has published numerous studies in peer-reviewed journals detailing his management of gastrointestinal malignancies.

UNIQUE ST. JOHN HOSPITAL & MEDICAL CENTER GASTRIC CANCER PROGRAM CELEBRATES ONE YEAR ANNIVERSARY

The Jerome F. Williams Gastric Cancer Program at St. John Hospital & Medical Center celebrated its one year anniversary this fall. The program started with a generous donation from the late Jerry Williams, a former gastric cancer patient, and his wife Anne Marie. Under the leadership of Richard Berri, MD, SJH&MC chief of Surgical Oncology, the program provides comprehensive, coordinated and compassionate care through expert clinical care and psychological, nutritional, emotional and spiritual support for gastric cancer patients. In the first year the team has treated close to 300 patients, with some

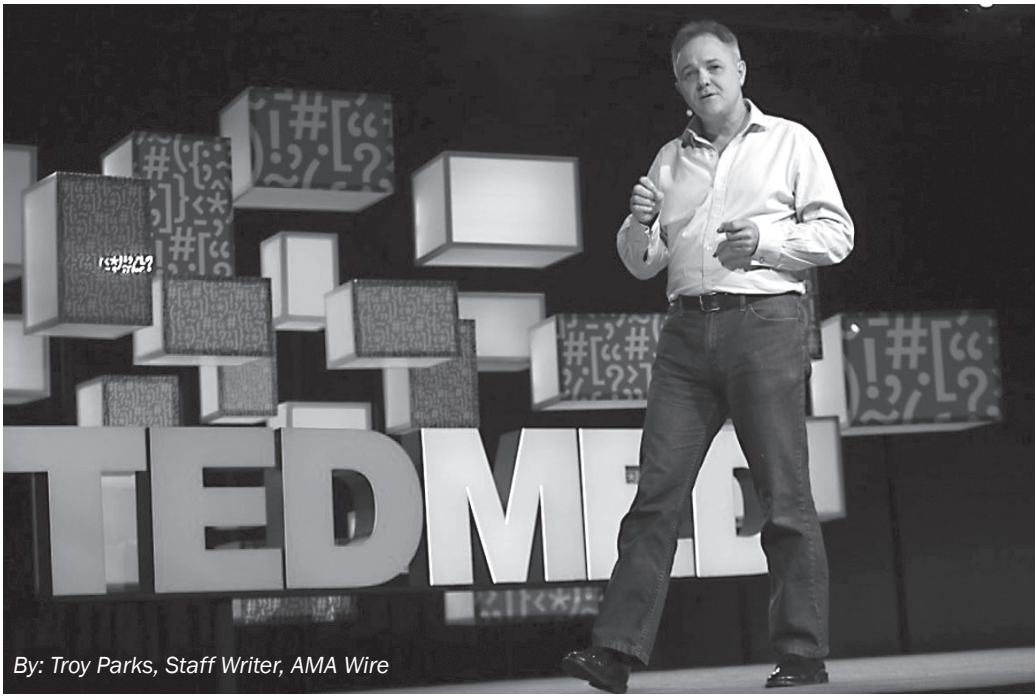
travelling throughout the Midwest and from the U.P. to receive treatment. Dr. Berri says it's the clinical team that differentiates the JFW Gastric Cancer Program. It's the only program in the state and among a few in the country with a surgical oncologist, gastroenterologist, medical oncologist, radiation oncologist, geneticist, social worker, dietician, nurse navigator and program coordinator. In addition, the program provides patient family housing that accommodates patients and their families who live more than 60 miles from SJH&MC. Goals for the second year include increasing the number of patients treated, extending the program's reach regionally, creating support groups and offering ongoing dietary classes for patients.

SJH&MC CHIEF OF INTERNAL MEDICINE HONORED WITH TEACHING AWARD



Lou Saravolatz, MD, Chief of Internal Medicine, St. John Hospital & Medical Center, was honored by Wayne State University this week at its yearly School of Medicine Awards. This annual event celebrates and honors Wayne State's faculty for their teaching and research achievements. Dr. Saravolatz received a College Teaching Award for Internal Medicine. Dr. Saravolatz has been a faculty member at Wayne State University for 20 years and this is the second time he has been honored with the School of Medicine teaching award. Congratulations!

How Epidemics Take Lives and Bring Global Health into Focus



By: Troy Parks, Staff Writer, AMA Wire

The world has seen a number of epidemics during the last 20 years, and due to globalization the threat of rapid spread has increased. In early December at TEDMED, a physician expert who was practicing in Vietnam during the outbreak of SARS explained the fear that comes with an epidemic and what the world has learned from working together and sharing information.

"All of us, at some point in our lives, are faced with some decisions and we don't really ever quite understand the implications," said Dr. Jeremy Farrar, a tropical medicine expert and director of the Wellcome Trust, a London-based biomedical research charity. After his medical training in neurology, Dr. Farrar moved to Vietnam, where he stayed for 18 years. And in February 2003, the SARS coronavirus that causes severe acute respiratory syndrome came to Vietnam.

"My professional life changed forevermore," he said. "A very good friend of mine, who was working for the World Health Organization in Hanoi, was worried." A person had flown from Hong Kong to Hanoi became very sick and was admitted to the hospital where his friend, Carlo Urbani, was working.

"The patient became much sicker over the next few days," he said. But Dr. Urbani noticed also that many of the doctors and nurses were getting sick as well. "Carlo, working with great partnership and trust with the Vietnamese authorities, made an incredibly brave decision - he effectively quarantined that hospital - and, as a result, saved the country from a terrible SARS epidemic," Dr. Farrar said.

Dr. Urbani alerted the world to the coming of SARS. He stayed in that hospital and looked after the patient. A few weeks later, he died as did a number of colleagues and friends.

"SARS lasted about six months, it spread to 14 countries and affected about 8,000 people, 800 of whom died. The World Bank estimated that those six months cost about $16 billion."

"At the end of SARS there was a sigh of relief and the world moved on. However, a few months later, it felt as if things came back," Dr. Farrar said. It was the Vietnamese holiday Tet.

Dr. Farrar was working in the hospital that night and received a phone call from a friend who said he was seeing a very sick young girl at another Hanoi hospital.

"The girl had a pet duck. And, tragically, the pet duck - the love of her life - died, and she buried it," Dr. Farrar said. "And then she had a big argument with her brother and she dug that duck up again, cuddled it one last time, and then reburied it."

A few days later, the girl got very sick and went to the hospital with a severe lung infection that progressed very quickly. "We had no idea if this was the recurrence of SARS - or whether this was something completely new," Dr. Farrar said. "All of us working in global health remember our history of 1918, when 14 million people died of flu. Fourteen million people. That's twice the number of people who died in the whole of the First World War."

"Was this something new, something never heard of, something we have no knowledge of?" he asked. "Working through that Vietnamese holiday, terrified of going home because you never knew what you might take home with you, we were able to show that this was not the recurrence of SARS.

All of us working in global health remember our history of 1918, when 14 million people died of flu. Fourteen million people. That's twice the number of people who died in the whole of the First World War.

This was a novel influenza virus which had presumably jumped across from her pet duck into this young girl."

The young girl got better and went home. "But over the course of the coming weeks and months we saw many patients who came in with very severe [and] aggressive lung infections across Vietnam, in Indonesia, across Southeast Asia and indeed in England. Over 16 percent of them died."

"We were left with a real sense of helplessness through SARs and bird flu," Dr. Farrar said. "We really were not sure of what we were facing. I remember being in a meeting with all of the doctors and nurses across Ho Chi Minh City. We were talking about the patients and what might happen and somebody coughed -and the room went silent."

Learning from the past

"It was a terrifying time. It was the most frightening time of my life," Dr. Farrar said. "In the intervening decade since, we've faced in the world a number of pandemics, some of which you've heard of: swine flu 2009. But some you may not have. There's a virus circulating in the Middle East at the moment which comes from camels, but which can affect humans and can pass from one human to another. It's been circulating for a few years now and we have no drug, we have no vaccine."

"We are facing a changing world," he said. "The environment is changing, the relationship between human beings and the natural world and human-animal interactions are changing as urbanization drives the 21st century. Global travel [has] allowed it to spread around the world, not in weeks but in hours."

With Ebola we learned some harsh lessons, he said. "The first phase of that epidemic was an absolute disaster. The three countries - Sierra Leone, Guinea and Liberia, - did not know what was happening. They had not the capacity to know that Ebola was spreading within their communities. And the world was far too slow to respond."

"But in the second phase of the epidemic, the world changed. We relearned the lessons that health systems, strong and resilient and robust health systems around the world, are absolutely crucial both to the national health of those countries and also to all of our health. They're essential to the global health security. And we must do everything we can to support those communities."

"We also know the importance of surveillance," Dr. Farrar added. "And [in] this modern world with smartphones and technology, the ability to identify things and share that information with colleagues and other countries is absolutely fundamental to saving lives."

Thanks to information sharing, Nigeria was forewarned and stopped Ebola before it could take off.

We learned that there are gaps in our knowledge, Dr. Farrar said. "If you look at SARS, if you look at MERS [Middle East Respiratory Syndrome], if you look at Ebola, we have no drugs and we have no vaccines. Imagine going to the clinic with your family and a doctor or a nurse tells you, 'I'm sorry, we have no treatment for you. Have no vaccine.'"

"It's unthinkable," he said. "But that's what's happened in all of these epidemics and at the end of each epidemic we've moved on - but I believe that this time will be different. During our Ebola epidemic, the amazing global coalition came together."

Out of Ebola came one phenomenal achievement. "Even in the height of that panic, we were able to show that a vaccine for Ebola works," Dr. Farrar said. "Never before during the course of an epidemic have we been able to show that."

"The power of science and the power of innovation and the power of the ability to lead and make bold decisions transformed an epidemic and that was an absolutely crucial lesson. "When we think of the future - when we really have the courage to try, we can change the world," he said.

At the start of the HIV/AIDS epidemic, Dr. Farrar was a young doctor. He saw many people die because there was no treatment. "But then we invested in science and we invested in people. We were able to bring antiretroviral drugs to the world and transform what was a death sentence into a manageable condition."

"Although I've been personally terrified, I go home in the evening fearing what I might take in there, remembering the lesson from Carlo Urbani, I also know that I've never been more optimistic of our ability to change the world," said Dr. Farrar. "If we grasp that moment, we can make the world a better place for everybody."

The world is a very small place, he said. What happens in Kathmandu will affect what happens in Kansas. "Remember that SARS devastated Toronto, Ebola came to London - Zika spread from Central and South America and is now in Florida. What happens in any part of the world will affect all of us."

St. John Macomb-Oakland Hospital
Dept. of Pathology and Laboratory Medicine

November 14, 2016

Suzanne Coats, Executive Director
Turning Point
225 South Main
Mount Clemens, MI 48043

Dear Sue,

Since I will be unable to attend my final Board meeting tonight, please share the following letter with fellow Board members and staff of Turning Point:

My interest in this organization goes back many years, initially through the Macomb County Medical Society, which has donated annually from its charitable foundation to TP for as long as I can remember. When I became president of MCMS in 1998, some members wanted to know more about TP as recipient of their donations and we arranged a visit to the old facility in Mount Clemens. This was, as many of you remember, a very old house lacking modern amenities, with sometimes multiple families, some with small children, sharing a single bathroom. Even in those circumstances, my fellow visitor and I were very impressed with all the activities of TP, with a bank of crisis phones being answered by student volunteers from Wayne State and other universities. We were taken on a tour of the Forensic Program facility for rape and sexual assault victims, then located in Henry Ford Macomb Hospital and learned about the preventative outreach program in schools and other venues to educate young people about domestic violence. Nowadays, this program has extended to young resident doctors to recognize victims of domestic violence-and sometimes of human trafficking, in local hospitals, all to help the neediest and most abused citizens of Macomb County.

When I became department chief at St John Macomb Hospital in 1994 and consequently had to attend the hospital Medical Executive Committee, the topic of donating from our medical staff fund to worthy charities in the region came up. TP immediately came to mind and members were very receptive to this proposal. We ended up instituting an annual donation from the medical staff, which has increased tenfold in amount since first agreed upon.

The building of the new facility in Mount Clemens was the highlight of my board membership and materialized within a short time span; though having been under consideration for many years. I am so proud that our medical staff with the leadership of Dr. Dhafer Salama, continues to donate annually to this most worthy of causes.

Sincerely,
Adrian J. Christie, MD

Anesthesiologists Treating Chronic Pain Patients

By: Jeremy Wale, JD, ProAssurance Risk Resource Advisors

NEARLY EVERY HOSPITAL IN THE UNITED STATES PROVIDES ANESTHESIA SERVICES TO PATIENTS. Most offer surgical services with general anesthesia, providing for safe operative care of patients. Such services bring risk exposures, many of which you can proactively mitigate.

An emerging area of risk for anesthesiologists involves treating chronic pain patients.

Some anesthesiologists sub-specialize in pain management, in addition or instead of traditional anesthesia services. Some patients prefer facilities that provide chronic pain management.

Pain management presents unique risks requiring proactive assessment, direction, and mitigation. Allegations against physicians in this area can include, but are not limited to, failure to treat, accidental overdose, causing addiction, or death.

Considerations when Managing Chronic Pain Patients

Start by assessing whether your facility has anesthesiologists and/or other physicians managing chronic-pain patients. If yes, consider several important issues.

Do you have a designated area or clinic for treating chronic pain patients?

A centralized location for treating these patients helps your facility:

1. track patients and providers; and
2. establish facility-wide policies and procedures for handling this unique medical population.

Another consideration when providing care for chronic-pain patients is the physician's qualifications for treating these patients. Pain management is a growing healthcare subspecialty, due in part to a reported 100 million Americans suffering from chronic pain.[1] According to the American Board of Medical Specialties, pain medicine is a subspecialty of anesthesiology, emergency medicine, and family medicine.

Consider employing board-certified pain medicine specialists in your clinic to treat chronic pain patients. These specialists' additional education and training will help ensure your chronic pain patients are being treated by qualified physicians.

Your facility can implement policies and procedures to help lessen potential risks of treating patients who require pain management.

A strong risk-reduction strategy may require each patient to enter into a pain management contract with the treating physician. This contract clearly and concisely outlines the physician's expectations of the patient and may include:

- The patient agrees not to accept narcotics prescriptions from other providers.
- The patient will not give or sell narcotics to others.
- The patient agrees to refrain from using drugs not specifically authorized by the physician.
- The patient is responsible for managing his or her medication to ensure he or she doesn't run out before scheduled visits/refills.
- The patient agrees to random drug testing.

This is not a comprehensive list for a pain management contract. Consult with your physicians and legal counsel to create a document that best fits your institution's needs.

Consider having a policy for ending your pain-management program's relationship with its patients. While best handled on a case-by-case basis, a policy aids consistency. Situations such as illicit narcotics use, persistent missed appointments, or suspected drug diversion are more common instances that typically require action.

Also consider what to do when a chronic pain patient enters your facility's ED. When these patients become addicted to opioid medications, they often run out of prescriptions early, and then try to secure narcotics by visiting the ED. An integrated EHR may help notify ED physicians these patients are being treated by a pain specialist; it may further aid understanding that the patient may not receive narcotic pain medications without consulting the pain-management physician.

Lastly, depending on your state, physicians may be able to monitor chronic-pain patients' prescription history via an electronic prescription monitoring program. Several states implemented such programs to help fight prescription drug abuse and diversion. Depending on the state, physicians may review a patient's prescription history. Be sure to review your state's rules to understand what you may access.

Key Considerations for Your Hospital's Anesthesia Services

The following summaries can help you and your facility's leadership review policies and procedures to mitigate risks involved with

anesthesia services, including those for chronic-pain patients.

- Does your facility treat chronic pain patients or have a pain management clinic?
- Do you utilize board-certified pain management specialists?
- Do your pain management physicians utilize a pain management contract? Is it sufficient?
- Does your ED have a protocol in place for handling potential drug-seeking patients?
- Do your ED physicians know how to determine whether patients are currently being treated by your pain management clinic or pain management physicians?

It is important for patient care and hospital liability that you take steps to proactively manage the risk around your facility's provision of anesthesia and care of chronic-pain patients. Establishing sufficient protocol and frequently checking in with staff to ensure their understanding are essential steps in effective anesthesia management and addressing the needs of chronic pain patients.

Source

1. IOM report. Relieving Pain in America. National Academies Press Web site. https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research/Pain%20Research%202011%20Report%20Brief.pdf. June, 2011. Accessed June 6, 2016.

Making Sense of MACRA: A Glossary of New Medicare Terms

By: Timothy M. Smith, Senior Staff Writer, AMA Wire

AS JOHN HARVEY, MD, PAST PRESIDENT OF THE MEDICAL ASSOCIATION OF GEORGIA, HAS TOURED HIS STATE TO DISCUSS THE UPCOMING MEDICARE PAYMENT TRANSITION, HE HAS NOTICED A TREND. "More than half the physicians I have talked to - were not aware of the terms MACRA, MIPS and APMs." Of course, there are also QPP, ACI and numerous non-initialisms that refer to crucial elements of the law that repeals the sustainable growth rate. Following is a short list of the terms every physician should know before the new payment rules take effect January 1, 2017.

Dr. Harvey, a general surgeon, was one of about 100 physicians to attend a recent MACRA educational session in Atlanta that was hosted by the AMA, the Medical Association of Atlanta, the Cobb County Medical Society and the DeKalb Medical Society. Another 100-plus viewed the presentation through a livestreamed webcast. The session provided an overview of the new payment program, compared it with its predecessor, offered a timeline for the program's implementation and delivered in-depth looks at the four participation options available in its transition year.

Before choosing a participation option, however, physicians will need definitions of the key elements of the program, beginning with the law itself:

MACRA: Short for the Medicare Access and CHIP Reauthorization Act of 2015. This is the law passed to reform the Medicare payment system. It repealed the sustainable growth rate formula, which calculated payment cuts for physicians. It also created a new framework for rewarding physicians who provide higher-value care.

QPP: The Quality Payment Program. This is that new payment framework. It offers two tracks for payment: MIPS and APMs, both discussed below.

MIPS: The Merit-based Incentive Payment System. MIPS aims to align three currently independent programs-quality reporting (what physicians know now as PQRS), Advancing Care Information (now known as EHR Meaningful Use), and cost (now known as the value-based modifier)-and adds a fourth component, Improvement Activities, designed to promote practice improvement and innovation. Some physicians will be exempt from MIPS through the low-volume threshold, defined below.

APMs: Alternative payment models. Few physicians will choose this track, as many APMs are not yet available in all states. APMs typically have shared savings, flexible payment bundles and other desirable features. There are two APM participation classifications-Advanced APMs, which have their own reporting requirements and are exempt from MIPS reporting, and MIPS APMs.

Pick your pace: This refers to the four participation options available in the transition year, which starts Jan. 1. Physicians may elect for MIPS testing, partial MIPS reporting, full MIPS reporting or Advanced APM participation.

Low-volume threshold: Physicians with less than $30,000 in annual Medicare revenue or fewer than 100 Part B-enrolled Medicare beneficiaries will be exempt from all MIPS reporting.

ACI: Advancing Care Information. This replaces Meaningful Use. It features more reasonable reporting features, including base and performance scoring, fewer measures and 90-day reporting periods.

Improvement activities: This new component, a feature of MIPS, is intended to provide credit for practice innovations that improve access and quality of care. It features more than 90 activities across eight categories. These too make accommodations for small practices.

Reporting option: Physicians will need to decide whether to report as an individual or as part of a group. A group is defined as two or more eligible clinicians. A physician in a group may choose to participate as an individual under MIPS.

Note: Except for those who qualify for the low-volume threshold, physicians who do not report any performance data in 2017 will be subject to a -4 percent payment adjustment when the new adjustments take effect, in 2019. Those who engage in partial or full reporting may be eligible for positive payment adjustments.

For more information on MARCA visit www.ama-assn.org/go/medicarepayment.

WHY WE SUPPORT DR. PRICE TO LEAD HHS

By: Patrice A. Harris, MD, MA, AMA Board Chair

The AMA supports the nomination of Dr. Tom Price based on decades of interactions with him as a member of the AMA House of Delegates, Georgia state senator and as a member of the House of Representatives since 2005. Over these years, there have been important policy issues on which we agreed (medical liability reform) and others on which we disagreed (passage of the Affordable Care Act). Two things that have been consistent are his understanding of the many challenges facing patients and physicians today, and his willingness to listen directly to concerns expressed by the AMA and other physician organizations.

An orthopaedic surgeon for nearly twenty years, Dr. Price would be the first physician to serve as secretary of the U.S. Department of Health and Human Services since President George H.W. Bush appointed Louis W. Sullivan, MD, in 1989, and only the third doctor to serve as secretary of the department in its 63-year history. That physician background will provide important perspective within the president's cabinet. Too often, health policy makers and regulators give short shrift to the real-world impact their plans and decisions can have on how patient care is delivered.

Even prior to his 2004 election to Congress, Dr. Price brought his physician experience to bear on health policy as a member of the Georgia Senate, where he served on the Health and Human Services Committee and supported efforts to improve child safety and expand patient choice. The AMA recognized his state legislative work with the Dr. Nathan Davis Award. More recently, Dr. Price has taken part as a speaker in AMA-organized policy events, such as a 2015 tele-town hall that prompted conversation on how to chart a better course on electronic health records.

An open door

A mainstay through the years has been Dr. Price's commitment to seek out and hear the concerns expressed by the AMA and other physician organizations. Even so, our support for Dr. Price to lead HHS should not be taken as an endorsement of every policy position he has advocated.

The conversation surrounding President-elect Trump's HHS choice caused me to reflect on a similar episode in the history of U.S. health care. When Ronald Reagan named pediatric surgeon C. Everett Koop, MD, as surgeon general, the move prompted a flurry of objections based on Dr. Koop's fervent opposition to abortion.

Despite that early resistance, Dr. Koop went on to become a powerful and constructive voice during the AIDS epidemic, helping to advance education, prevention and treatment responses that reduced stigma, deaths and suffering. He also released eight reports on tobacco use's baleful health consequences and promoted the goal of a smoke-free society. Dr. Koop's one-time opponents later cited him as a role model for how the U.S. surgeon general can help the nation face serious health care challenges.

The AMA will actively engage Dr. Price, other leaders in the incoming Trump administration and Congress in discussions on the health system's future direction. We remain devoted to improving health insurance coverage so that patients receive timely, high-quality care, preventive services and other necessary medical treatments. And for us, a core principle with regard to any proposed health system reform is that it should not cause anyone who has health insurance coverage now to lose it.

We look forward to a continuing conversation with Dr. Price as we work together on the health care priorities where we share common ground.

$1 BILLION OPIOIDS PACKAGE PASSED WITH "CURES" BILL

On December 7, the Senate completed consideration of the "21st Century Cures Act," approving the bill by a vote of 94 to 5. The House passed the bill 392 to 26. After several years of hearings, meetings and negotiations, and with bipartisan support from Congress and the White House, the $6.3 billion medical innovation package is intended to accelerate the discovery, development and delivery of new therapies, including $1 billion to help states address the opioid epidemic.

As with any legislative package of this size, there are provisions which have the support of physicians and provisions that raise some concerns. However, in the interest of advancing the many positive elements of the final bill, the AMA is in support of the final product.

Importantly, $1 billion will be distributed to states over two years to assist in addressing the epidemic of opioid misuse and abuse through:

- Improving state prescription drug monitoring programs (PDMP).
- Implementing prevention activities and evaluating such activities to identify effective strategies to prevent opioid abuse.
- Training for health professionals, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral to treatment programs and overdose prevention.
- Supporting access to health care services, including those provided by federally certified opioid treatment programs or other health professionals to treat substance use disorders.
- Other public health-related activities, as the state determines appropriate, related to addressing the opioid abuse crisis within the state.

DOCTORS AGAINST HEALTH REFORM? NOT SO FAST

By: Andrew W. Gurman, MD, President
American Medical Association

Without a firm grounding in relevant facts and history, it is easy for a reporter to take shelter in outdated memes or incorrect notions. In a recent New Yorker column, "How Doctors Could Thwart Health-Care Reform," the author unfortunately does both.

Improving public health and the health of our nation has been top priority for the American Medical Association throughout our rich and storied history. In fact, it is our mission to promote the art and science of medicine and the betterment of public health. We evaluate proposals based on their merits and have certainly opposed reform efforts we deemed wrongheaded or harmful. In recent years, our organizationñand physicians across our countryñput skin in the game, fought for principles we believe in, and strongly advocated for health reform. Let me tell you how:

In 2006, AMA leadership made a commitment to advancing health insurance coverage for all Americans, fueling our support for the Affordable Care Act, which became law in 2010. Regardless of which party is in the White House or in control of Congress, we will continue to be a strong advocate for universal health insurance coverage until this goal is attained. Twenty million more people have access to care today as a result of this law ñ which is improving health and helping people live more productive lives. While no law is perfect, we have consistently argued for improvements that will help both patients and physicians.

In 2015, after a decade of fierce advocacy, the AMA also worked with Congress to secure bipartisan passage of the Medicare Access and CHIP Reauthorization Act, the most transformative legislation to affect health care delivery for our nation's senior citizens in more than 30 years. As a result of this law, we have the potential to improve care and lower overall health care costs through a new framework for rewarding physicians who provide higher-value care.

The AMA is also shaping the future of health care. Because of our collaborative work, a quarter million Americans self-screened for prediabetes; we described and published a textbook on health system science, which will become the third pillar of medical education alongside basic science and clinical rotations; and we supported productive digital health innovation by creating connection points between physicians and innovators.

It is our unwavering commitment to our patients and our profession that called us to lead a national conversation about responsible opioid prescribing. This year, we saw notable progress in this urgent fight, from fewer prescriptions written to better access to Naloxone. It was AMA analysis that led the U.S. Dept. of Justice and state regulators to move to block two proposed health mega mergers. It was a new campaign through TruthinRx.org that stimulated grassroots pressure to address growing concerns about escalating drug prices.

As we enter a new era under the new administration and Congress, the AMA's policy-making body reaffirmed its commitment to health care reform that improves access to care for all patients. A core principle is that any proposed policy should not cause an individual currently covered to become uninsured. We remain committed to ensuring proposed changes in health coverage provide adequate access, choice and coverage and the advancement of high quality care. These are important values for patients, physicians, and our country.

In the headline of his New Yorker column, the author implicitly alleges that every proposal for reform is good reform, but I can assure you this is not true. What is true is that patients and their doctors can depend on our thoughtful review of national health reform proposals in the months ahead.

Physicians know that people without insurance live sicker and die younger. This is why the AMA will hold true to our mission and work to increase access to health care and improve the health of our nation.

WITH HANDOFF RISK QUANTIFIED, 3 WAYS TO IMPROVE CARE TRANSITIONS

Evidence indicates that shift-to-shift handoffs are related to increases in adverse events and patient mortality. And a new study examines the link between death risk and end-of-rotation transitions, but what kinds of strategies can work in practice to minimize the handoff hazard?

A study published in the recent Journal of the American Medical Association (JAMA) theme issue on medical education asks the question, "Are patients who are exposed to end-of-rotation resident transition in care at risk for greater mortality?"

Examining more than 230,000 patients admitted to internal medicine services in 10 Veterans Affairs (VA) hospitals, the study found that end-of-rotation house staff transition in care was associated with significantly higher in-hospital mortality when handoffs involved only interns, or interns and residents. But they the death rate was not higher when transitions involved only residents. The higher death risk "may be limited to longer-stay, complex patients with greater comorbidities or those discharged soon after the transition," the authors concluded.

In an editorial, "Inpatient Service Change: Safety or Selection?" Vineet M. Arora, MD, pointed out that "patients who remain hospitalized during a change in personnel on the inpatient service are likely different than those who are discharged. This selection helps to explain the increased mortality with service changes reported in

the study."

"Given well-documented content omissions during handoffs, it is plausible that poor information exchange during service change contributed to increased in-hospital mortality," wrote Dr. Arora, director of graduate medical education (GME) clinical learning environment innovation at the University of Chicago.

But, she wrote, there are alternative explanations. For example, a patient admitted before transition may receive less attention from the team that admitted them since they will not continue that patient's care throughout their hospital stay. Or the team taking over "may perceive they never really ëowned' a patient they did not admit."

"In contrast, an intern-resident service change could facilitate a ëfresh look' at an ill patient who may not benefit from ongoing intervention," Dr. Arora said.

The findings yet again draw attention to the critical importance of improving in-hospital care transitions.

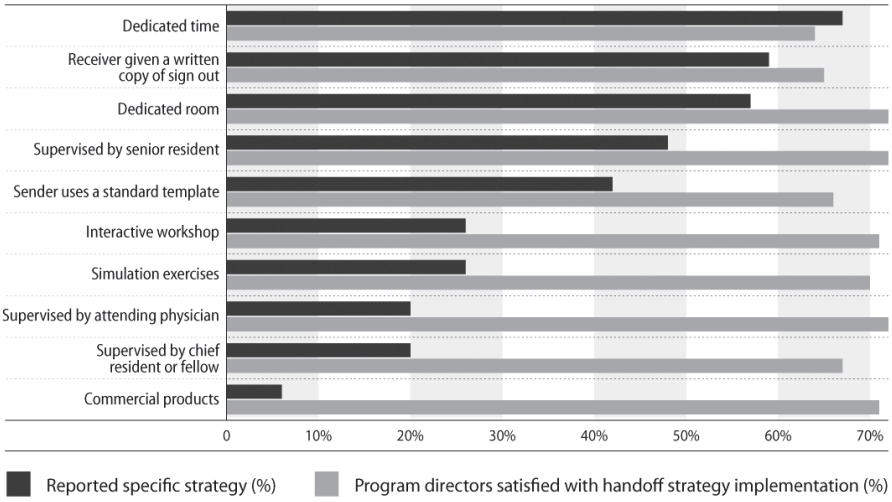
Dr. Arora also helped conceive and design a survey whose results were included in the JAMA medical education theme issue. The survey which asked residency programs which techniques they were using in practice to make handoffs smoother and safer for patients. These included educational resources, carving out dedicated time for handoffs and adding supervisors to transitions, among others (right).

Dr. Arora works closely with residents every day. When asked about some of the ways she's found to make transitions in care at end-of-rotation easier for residents, she offered three examples:

- Standardizing templates to help with transfer of content: This is "especially important since service changes often require more information about disposition and discharge planning than a traditional shift handoff," Dr. Arora said.
- Structuring handoffs so there is enhanced continuity of team members: "Instead of everyone changing at once," she said, "either the resident or attending stays on the team a bit longer so there is someone on the team who knows the patient."
- Encouraging the patient and their family to be more involved: "Studies suggest they often don't know a handoff has occurred," Dr. Arora said. "We have piloted bedside handoffs at service change for select patients to see if that could help [and] the pilot was demonstrated to be feasible in our hospitalist program. One challenge is structuring a shift or protecting time for hospitalists to do it, [which] may be harder to do in a resident program but it's worth considering ways to empower patients and caregivers in this way."

"It is reasonable to suggest that service changes may be risky for patients and to explore ways to improve them," Dr. Arora said. "Until further research elucidates the reasons why mortality may increase at these times, academic health centers must remain committed to ensure the safety of patients at all times, especially those patients undergoing service changes."

Handoff strategies and satisfaction of program directors of internal medicine training programs



Thanks to Your Generosity the 2016 MCMS Foundation Holiday Sharing Card Project Raised $4,785

We would like to thank the MCMS members who participated in the 2016 MCMS Foundation Holiday Sharing Card Project. Due to your generous donations we were able to raise $2,250 for the Macomb County Food Program and $2,535 for Turning Point Shelter for women.

New Members

EASTPOINTE RADIOLOGISTS, PC

The following physicians practice at

36175 Harper Avenue, Clinton Township, MI 48035, Ph. 586-741-3772, Fx. 586-741-4604, website www.eastpointeradiologists.com

JEREMY S. FELDMAN, MD

Diagnostic Radiology - Board Certified

Medical School: Medical College of Wisconsin, 2009. Post Graduate Education: Hahnemann University Hospital; University of Michigan, completed 2014. Hospital Affiliation: Henry Ford Macomb, St. John Hospital & Medical Center.

FAIZ D. FRANCIS, DO

Diagnostic Radiology - Board Certified

Medical School: Michigan State University, 2008. Post Graduate Education: St. John Providence Hospital; Indiana University School of Medicine, completed 2013. Hospital Affiliation: Henry Ford Macomb, St. John Hospital & Medical Center.

NANCI M. MERCER, MD

Diagnostic Radiology - Board Certified

Medical School: Medical College of Pennsylvania, 1995. Post Graduate Education: Oakwood Hospital; William Beaumont Hospital (Neuroradiology); University of Chicago (Abdominal Imaging), completed 1999. Hospital Affiliation: Henry Ford Macomb, St. John Hospital & Medical Center.

SUNDEEP H. PATEL, MD

Diagnostic Radiology - Board Certified

Medical School: Ross University School of Medicine, 2007. Post Graduate Education: St. Joseph Mercy-Oakland Hospital; William Beaumont Hospital, completed 2012. Hospital Affiliation: Henry Ford Macomb, St. John Hospital & Medical Center.

CORY Z. TRIVAX, MD

Diagnostic Radiology - Board Certified

Medical School: Wayne State University, 2003. Post Graduate Education: St. John Providence Hospital; Henry Ford Hospital, completed 2008. Hospital Affiliation: Henry Ford Macomb, St. John Hospital & Medical Center.

MICHAEL P. TRPKOVSKI, MD

Diagnostic Radiology - Board Certified

Medical School: Wayne State University, 2007. Post Graduate Education: William Beaumont Hospital; University of Michigan, completed 2012. Hospital Affiliation: Henry Ford Macomb, St. John Hospital & Medical Center.

STEVEN F. ZUSKA, MD

Diagnostic Radiology - Board Certified

Medical School: St. George's University. Post Graduate Education: St. Joseph Mercy-Oakland Hospital; William Beaumont Hospital, completed 2011. Hospital Affiliation: St. John Hospital & Medical Center.

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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.*

Macomb County Health Department Reportable Diseases Summary
Diseases Reported - Note: Cumulative total for previous years; year-to-date for NOVEMBER 2016

	2016	2015	2014
AMEBIASIS	1	0	1
BLASTOMYCOSIS	0	0	1
BOTULISM (FOODBORNE)	0	0	0
BOTULISM (INFECTIOUS)	0	0	0
BRUCELLOSIS	0	0	0
CAMPYLOBACTER	92**	78**	86**
CHICKENPOX	32**	32**	88**
CHLAMYDIA	2,762	2,735	2,468
COCCIDIOIDOMYCOSIS	1	2	7
CREUTZFELDT JAKOB	2	1**	2**
CRYPTOCOCCOSIS	1	1	2
CRYPTOSPORIDIOSIS	9**	1**	9**
DENGUE FEVER	1	1	0
DIPHTHERIA	0	0	0
EHRLICHIOSIS	3**	0	1**
ENCEPHALITIS PRIMARY	1	2	2
ENC POST OTHER	1	1	2
FLU-LIKE DISEASE	19,303	27,943	28,824
GIARDIASIS	19	17	21
GONORRHEA	672	514	474
GRANULOMA INGUINALE	0	0	0
GUILLAIN-BARRE SYNDROME	10**	4**	6**
HEMOLYTIC UREMIC SYN.	0	0	0
HEPATITIS A	9	5	4
HEPATITIS B (ACUTE)	8	6	7
HEPATITIS B (CHRONIC)	102**	132**	141**
HEPATITIS C (ACUTE)	30**	16**	15
HEPATITIS C (CHRONIC)	878**	688**	705**
HEPATITIS D	0	0	0
HEPATITIS E	0	0	0
H. FLU INVASIVE DISEASE	11	11	9
HISTOPLASMOSIS	2**	5**	2**
HIV^	68	76	54
INFLUENZA	1,200	764	820**
KAWASAKI SYNDROME	5	10	5
LEGIONNAIRE'S DISEASE	32	24	24
LISTERIOSIS	1	1	1

	2016	2015	2014
LYME DISEASE	3	7	1
MALARIA	2	2	1
MEASLES	0	0	0
MENINGITIS VIRAL	38**	60**	44**
MENINGITIS BACTERIAL/BACTEREMIA (EXCLUDING N. MENINGITIDIS)	8	10	8
MENINGOCOCCAL DISEASE	1	1	1
MUMPS	2**	0	2**
PERTUSSIS	29**	35**	83**
POLIO	0	0	0
PSITTACOSIS	0	0	0
Q FEVER	0	0	0
RABIES ANIMAL	0	1	3
RABIES HUMAN	0	0	0
REYE SYNDROME	0	0	0
ROCKY MNTN SPOTTED FVR	0	0	0
RUBELLA	0	0	0
SALMONELLOSIS	69	82	75**
SHIGELLOSIS	47	21	9
STEC***	6	8	11
STREP DIS, INV, GRP A	26	27	26
STREP PNEUMO, INV + DR	52	52	45
SYPHILIS	52	104	77
SYPHILIS CONGENITAL	0	1	0
TETANUS	0	0	0
TOXIC SHOCK SYNDROME	0	0	1
TUBERCULOSIS	9	6	11
TULAREMIA	0	0	0
TYPHOID FEVER	0	1	1
VIBRIOSIS	1	0	0
VISA	0	0	1
WEST NILE VIRUS	2	4**	0**
YELLOW FEVER	0	0	0
ZIKA	4	0	0

**INCLUDES BOTH PROBABLE & CONFIRMED CASE REPORTS
***Shiga-toxin producing Escherichia coli per MDCH; combo of E. coli & Shiga Toxin 1 or 2
^ Previously reported as "AIDS"

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