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

By: Gary L. Shapira, MD
MCMS President

IN MY PREVIOUS COLUMN FOR THE MACOMB MEDICUS (JAN/FEB 2015), I COVERED HOW HOME THEATER EQUIPMENT AND SET-UP WERE SIMILAR TO HEALTH CARE REFORM INFRASTRUCTURE AND SET-UP. In this column I will begin the evaluation of home theater and of health care reform.

The first way I evaluate a home theater is whether or not I have the urge to change something. This is not an absolute criterion. Some people have superb home theaters but constantly change speakers, amplifiers, source components, and lay-outs. But in general, a quality home theater provides a movie or music experience without suggesting a change. In my case, I have not changed anything for years. That supports a quality home theater.

This brings us to the first way to evaluate health care reform. Have there been any changes? There have been many changes since the Patient Protection and Affordable Care Act (ACA) was implemented. The lynchpin of the entire ACA is that everyone has broad insurance. Basically if the young and healthy buy insurance for medical conditions they do not have, then the cost will be reasonable for those who do have medical conditions. In the ACA, the government has mandated what is required to be covered. And the government has mandated penalties if someone lacks insurance which covers the required conditions.

In theory this would work if everyone had broad insurance. But the ACA is not a theory, it is a law. And people are getting around this law.

According to the Galen Institute (www.galen.org), as of January 7, 2015 there have been 46 changes to the ACA of which 28 were by administrative action. Administrative actions delayed the employer mandate (7/2/2013 and 2/10/2014), the individual mandate (10/23/2013), the sign-up deadline (3/26/2014) and the requirement for equal coverage for all employees (1/18/2013). Administrative actions exempted members of Congress and their staffs (9/30/2013), unions (12/2/2013), and U.S. territories (7/18/2014). Changes through administrative action included subsidies may flow through federal exchanges (5/23/2012) and non-exchange plans (2/24/2014). Also insurance companies may offer canceled plans (11/14/2013) and non-compliant plans get a two year extension (3/5/2014).

So by administrative actions, the ACA no longer requires either everyone to be covered or all government approved conditions to the covered. These many basic changes support that the ACA is a defective law.

As a bonus, these are the current tax penalty exemptions from Obamacarefacts.com which are either automatic or may be applied for:

- Unaffordable Coverage Options (Insurance costs more than 8% income after subsidies).
- Low Income/No Tax Filing Requirement (About $10,000 single, about $20,000 married).
- Short Coverage Gap Exemption (less than 3 consecutive months).
- Religious Conscience.
- Health Care Sharing Ministry.
- Not Lawfully Present (An undocumented immigrant).
- Incarceration.
- Indian tribes.

Hardship Exemptions (14):

1. You were homeless.
2. You were evicted in the past 6 months or were facing eviction or foreclosure.
3. You received a shut-off notice from a utility company.
4. You recently experienced domestic violence.
5. You recently experienced the death of a close family member.
6. You experienced a fire, flood, or other natural human-caused disaster that caused substantial damage to your property.
7. You filed for bankruptcy in the last 6 months.
8. You had medical expenses you couldn't pay in the last 24 months.
9. You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
10. You expect to claim a child as a tax dependent who's been denied

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SESQUICENTENNIAL MSMS HOUSE OF DELEGATES MOVES TO TWO-DAY FORMAT

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

To increase efficiency and better respect the time commitment of the delegates, the 150th Annual House of Delegates will be a two-day meeting on Saturday, May 2, and Sunday, May 3, 2015, at the Amway Grand Plaza in Grand Rapids.

House Speaker Pino D. Colone, MD, said the revisions to the agenda reflect continued feedback by delegates for many years, but most recently at the 2014 House of Delegates meeting and in a delegate survey in late 2013. The Saturday-Sunday format for 2015 is based on the facility contract and is a considered a pilot.

"We believe we were successful in keeping all essential House functions scheduled within the two-day weekend," Doctor Colone said in announcing the change to delegates. "We ask that delegates be open and flexible as we attempt to reinvent the annual meeting to meet the needs of all of our members."

An announcement about the officers running for re-election will be forthcoming.

The House of Delegates is the official policy-making body of the Michigan State Medical Society. Resolutions and Board Action Reports are the vehicles used to debate and determine the policies, priorities, and direction of MSMS during the ensuing 12 months and beyond. Resolutions are presented to the MSMS House of Delegates by voting delegates on behalf of their county delegation, specialty society, ethnic medical society, MSMS membership section, or as individual delegates.

All resolutions must be submitted online via the Online Submission Form. Go to the House of Delegates Webpage at www.msms.org/hod to submit a resolution. Resolutions need to be submitted to MSMS by 11:59 p.m. on Monday, March 2, 2015, to be included in the 2015 House of Delegates handbook. Resolutions received after March 2, 2015, will be considered late resolutions and will be referred to the Committee on Rules and Order of Business, which meets on Saturday morning.

UPDATE ON MEDICAID PRIMARY CARE UPLIFT

The Michigan Department of Community Health (MDCH) recently released a final bulletin (MSA 14-61) that explains how increased payments for Medicaid primary care services (uplifts) rendered by primary care physicians will be paid in 2015. MSMS advocated for practice characteristics (60% of specified evaluation and management codes) to be added as one of the eligibility criteria. We are happy to report that provision was included in the final version.

The current Medicaid primary care uplift was authorized by the Patient Protection and Affordable Care Act (ACA). Because it expired in 2014, the Michigan Legislature included a partial continuation of the Medicaid primary care enhanced rates to Medicare rates beyond December 31, 2014 in the Fiscal Year 2015 MDCH budget (Section 1801 of Public Act 252 of 2014).

This extension will enable physicians with a specialty designation of family medicine, general internal medicine, and pediatric medicine who provide certain primary care services to be reimbursed at approximately 78 percent of Medicare rates for dates of service on and after January 1, 2015. Payments will be made on qualified procedure codes. To be eligible for the adjusted payment, physicians must be board certified or board eligible in one of the three designed primary care specialties recognized by the American Board of Medical Specialties, American Osteopathic Association, and the American Board of Physician Specialists. Non-board certified or non-board eligible primary care physicians may be eligible for the uplift if a review of their billing history demonstrates that at least 60 percent of the physician's codes paid by Medicaid are for E/M codes specified in the policy.

Physician practitioners whose CHAMPS Provider Enrollment profile information reflects that they provide specialty or subspecialty, (e.g. cardiology, endocrinology, or oncology, etc.) services will not be eligible for the adjusted payment in 2015. Physicians with multiple subspecialties will also not be eligible for the adjusted payment in 2015. Exceptions will be made for practitioners who have subspecialty practices in adolescent and geriatric medicine.

Physicians must update and maintain their primary specialty designations in their Community Health Automated Medicaid Processing System (CHAMPS) enrollment profile. Because the enhanced payment has not been disclosed, please work with the health plans to define the enhanced capitated payment. As you contact the health plans to determine that enhanced capitated payment, please verify with them your specialty as the state will not provide an eligibility roster to the health plans.

Physicians may see the enhanced rates by visiting the MDCH website.

After meeting with Medicaid, MSMS confirmed the increase is intended to be paid to the physician/employer in full. The increase is not to cover administrative costs.

If you have further questions, contact Stacie J. Saylor, CPC, CPB, at (517) 336-5722 or ssaylor@msms.org.

HHS ANNOUNCES GOALS & TIMELINE TO MOVE MEDICARE TO NEW PAYMENT MODELS

Health and Human Services (HHS) Secretary Sylvia M. Burwell has announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients, according to a news release from HHS.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018, according to the HHS announcement.

The full news release can be seen at: www.hhs.gov/news/press/2015pres/01/20150126a.html

"Physicians have many ideas for redesigning and improving the delivery of high-quality patient care in this country," said American Medical Association president Robert M. Wah, MD, in response to the HHS announcement. "We strongly support reform of the Medicare payment system, including elimination of Medicare's flawed sustainable growth rate formula, which provides a pathway for physicians to innovate and develop new models of health care delivery for our patients. We look forward to hearing more details behind the percentages HHS put forward as well as their plans to reach these percentage targets."

Doctor Wah's full statement can be seen at: www.ama-assn.org/ama/pub/news/news/2015/2015-01-26-hhs-shifting-medicare-reimbursements-volume-value.page

TELEMEDICINE IMPROVES ACCESS TO CARE BUT CREATES LIABILITY RISKS

Telemedicine involves the delivery of health care to patients in remote locations and to underserved patient populations through audio-visual, online, and wireless applications. This leads to improved access to medical care and consultation, more efficient treatment plan implementation, cost savings for patients, and increased patient satisfaction.

The use of telemedicine is growing, and the Centers for Medicare and Medicaid Services recently announced that in the 2015 physician fee schedule, Medicare payments to telehealth originating sites will increase by 0.8 percent. However, numerous federal and state statutes have created significant liability risks for medical practitioners who engage in any form of telemedicine.

Physicians who engage in telemedicine across state lines face serious considerations. The scope of practice is generally determined by the location of the patient. Providing care to a patient located in a different jurisdiction requires the practitioner to satisfy the licensing requirements of the state in which the patient is located. Without proper licensure,

adverse consequences might include criminal prosecution for the unlicensed practice of medicine or disciplinary action by a medical board. Physicians should also be aware that their professional liability policy may not cover a claim that is filed outside a specific territory or jurisdiction.

To reduce these liability risks and enhance patient safety:

- Comply with HIPAA, HITECH, and state-specific laws when transmitting all PHI.
- Ask your system vendor to provide training to you and your staff on how to protect and secure your data.
- Ensure robust and reliable high-speed broadband connectivity to support clinical functions.
- Check practice requirements and legal limitations in states where you anticipate providing care to patients. Understand reimbursement practices for telemedicine services.
- Use telemedicine carefully -- and understand any limitations on the reliability and accuracy of the information.
- Communicate directly with your professional liability insurer to make certain that your policy extends coverage to all jurisdictions where you provide services.

GOVERNOR SNYDER SIGNS EXPEDITED PARTNER THERAPY INTO LAW

Governor Rick Snyder held a bill signing ceremony in February for HB 4736, Expedited Partner Therapy (EPT). In 2012 the MSMS House of Delegates passed HOD Resolution 1 which said MSMS would support the implementation of the policy in Michigan.

Public Act 525 of 2014 authorizes EPT for treatment of sexually transmitted infections, allowing for physicians to prescribe infected individuals and their partners and for pharmacists to fill those prescriptions.

Representing the Michigan State Medical Society was Doctor Cheryl Gibson-Fountain, citing "this is a great victory for public health and for MSMS."

PRESIDENT-ELECT ROSE RAMIREZ, MD, PRESENTS TO MICHIGAN HOUSE HEALTH POLICY COMMITTEE

In early February, Michigan State Medical Society President-elect Rose Ramirez, MD, presented in front of the Michigan House of Representatives Health Policy Committee. The purpose of her presentation was to introduce and reintroduce MSMS to the new and returning committee members.

In addition to talking about MSMS' 150 year history, Doctor Ramirez highlighted various ways MSMS would like to work with the Health Policy Committee. "We are in a time of tremendous change in health care. Physicians are ready to be leaders in making the changes that improve care for our patients. Your constituents are our patients, so we look forward to partnering with the Health Policy Committee in terms of passing legislation that will make Michigan a leader in health care, in areas such as:

- Public health and population health initiatives
- Reducing bureaucracy and unnecessary administrative costs
- Appropriately defining team based health care
- Maximizing access to health care in underserved areas
- Innovate graduate medical education
- Reducing prescription drug abuse."

MEMBER BENEFIT: The practice of medicine is much stronger when we have physicians involved in organized medicine. Together with you, MSMS will continue working on common sense legislation, protecting your rights as a physician and the interests of your patients.

President's Page, *continued from pg. 3*

coverage in Medicaid and the Children's Health Insurance Program (CHIP), and another person is required by court order to give medical support to the child.

11. As a result of an eligibility appeals decision, you're eligible either for:1) enrollment in a qualified health plan (QHP) through the Marketplace, 2) lower costs on your monthly premiums, or 3) cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace.
12. You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.
13. You received a notice saying that your current health insurance plan is being cancelled, and you consider the other plans available unaffordable.
14. You experienced another hardship in obtaining health insurance.

The number of Americans who may qualify for an exemption has been estimated at 20 million.

In my next column I will discuss other ways of evaluating a home theater and apply it to the Affordable Care Act.

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Henry Ford Macomb Hospital

THE MEDALLION: MACOMB'S GALA EVENT CELEBRATES 25 YEARS OF SUPPORTING THE HEALTH NEEDS OF MACOMB COUNTY

For 25 years, Henry Ford Macomb Hospitals and the community have come together to raise funds for critical health care needs while honoring those who have worked to significantly enhance Henry Ford Macomb during the past year.

With that in mind, The Medallion: Macomb's Gala Event silver anniversary celebration promises to be the most glamorous event of the year. The black-tie themed event is March 7 at Penna's of Sterling and will benefit Surgical Services at Henry Ford Macomb Hospital.

The 2015 Medallion honorees include:

- **Tony Viviano Distinguished Achievement Award** - Larry Scott
- **Physician** - Anthony Munaco, MD
- **Leader** - Wendy Hamilton, RN
- **Nurse** - Charles Koerber, RN
- **Staff** - Jason Champine, PA-C
- **Volunteer** - Meaghan O'Callaghan
- **Citizen** - Tom Fiebelkorn

In addition to recognizing the Medallion honorees, the evening features 1,000 attendees for a spectacular dinner, dancing, mock gambling and a grand package raffle. Raffle packages this year will feature:

* A trip for two aboard the Detroit Red Wings Red Bird One to travel with the hockey team to an away game.

* A fabulous seven-day trip to the Tuscany region of Italy.

* Two spectacular electronics packages.

You need not be present to win at the raffle and tickets are on sale now. For more information, contact the Henry Ford Macomb Department of Philanthropy at (586) 263-2960.

Tickets to the gala are $250 each and sponsorship opportunities are also available. For more information or to order tickets, go to www.henryfordmacomb.com/medallion.

ANTHONY MUNACO, MD MEDALLION PHYSICIAN HONOREE

As medical director of Medical Imaging and Diagnostic Radiology, Dr. Munaco oversees a large number radiologists in a range of subspecialties that serve the entire organization.

"He is an excellent physician," notes one nominator. "An expert in several subspecialties, he is the 'go-to' guy for clinicians who come down for help. He is the glue that molds an excellent department with a core of excellent radiologists, technologists and supervisors."

Dr. Munaco and his wife, Denise, have served as chairs of the Medallion event in the past.

"This is a great organization and it's a pleasure to be involved in events like The Medallion," he said. "The administration's approach to quality is excellent and the referring physicians are good to work with. The hospital itself is like a family."

Dr. Munaco is board certified in radiology. He earned his medical degree from Wayne State University and completed his residency in diagnostic radiology at William Beaumont Hospital. He also completed a fellowship in body cross-sectional imaging at Beaumont.

He has been on a number of hospital committees over the years, including the Medical Executive Committee. He also has been a clinical assistant professor of radiology at the Michigan State College of Osteopathic Medicine.

"I try to meet the needs of our referring physicians and treat our patients right," he added. "I try to be available and answer questions. If issues arise, I try to solve them as soon as possible."

Dr. Munaco lives with his wife, Denise and their three children in Oakland Township.

BODY CONTOURING AFTER BARIATRIC SURGERY HELPS OBESE PATIENTS

Patients who have plastic surgery to reshape their bodies after bariatric procedures are able to maintain "significantly greater" weight loss than those who do not have surgery, according to a new study by Henry Ford Hospital researchers.

"As plastic and reconstructive surgeons, we are encouraged by the idea that improved body image can translate into better long-term maintenance of a healthier weight, and possibly a better quality of life for our patients," says Donna Tepper, MD, a Henry Ford plastic surgeon and senior author of the study.

Study results were presented Oct. 11, 2014 at the annual conference of the American Society of Plastic Surgeons in Chicago.

"Bariatric surgery has a measurably significant positive impact on patient illness and death," Dr. Tepper says. "However, even with the technical and safety advancements we've seen in these procedures, their long-term success may still be limited by recidivism. "There is a high incidence of patients who regain weight after the surgery."

The new study followed 94 patients who underwent bariatric surgery at Henry Ford from 2003 through 2013. Of those, 47 subsequently had body recontouring procedures. Some previously obese patients opt for plastic surgery - such as face or breast lift, so-called "tummy tuck" or lifts of sagging upper arms, thighs or buttocks - to remove inelastic excess skin and tissue after substantial weight loss and to reshape or recontour their bodies.

Henry Ford researchers recorded each patient's Body Mass Index, or BMI - a weight-to-height ratio used to determine degrees of obesity - both before their bariatric surgery and 2.5 years after the procedure.

"Of the patients who underwent contouring surgery, the average decrease in BMI was 18.24 at 2.5 years, compared to a statistically significant 12.45 at 2.5 years for those who did not have further surgery," Dr. Tepper explains.

While these findings suggest that aesthetic procedures following bariatric surgeries may contribute to improving their long-term results, Dr. Tepper says future studies will look at changes in BMI after five years, as well as how different types of contouring procedures may maintain weight loss.

St. John Macomb Oakland Hospital

ST. JOHN MACOMB-OAKLAND HOSPITAL IS SPORTING A NEW CATHETERIZATION LABORATORY

St. John Macomb-Oakland Hospital, Macomb Campus is home to a new catheterization lab, and is home to one of the first Siemens Artis cath labs to be installed in the United States. The Siemens Artis technology provides higher quality imaging with less contrast and radiation exposure to the patient. The new technology has allowed St. John Macomb-Oakland Hospital to expand services, including coronary and peripheral procedures, device implants and EP studies.

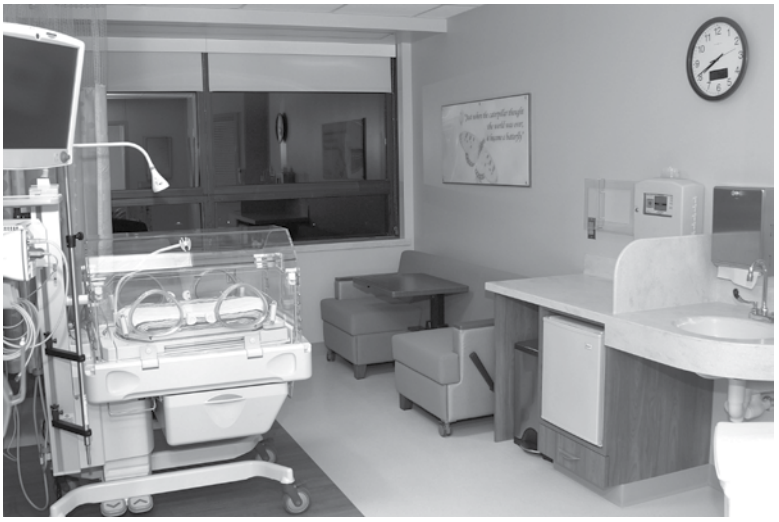
AED DONATED TO SHERIFF'S SWAT TEAM

In January, John Floreno, DO, executive director of the Macomb County Osteopathic Medical Association; St. John Macomb-Oakland Hospital President Terry Hamilton and Chad Kovala, DO, president of the Macomb County Osteopathic Medical Association presented an automated external defibrillator to the Macomb County Sheriff's Office for the department's SWAT team. Dr. Kovala, who also serves as the SWAT team physician, said the equipment can mean the difference between life and death during various law enforcement situations on the street. All of the team members will be trained to use the life-saving device.

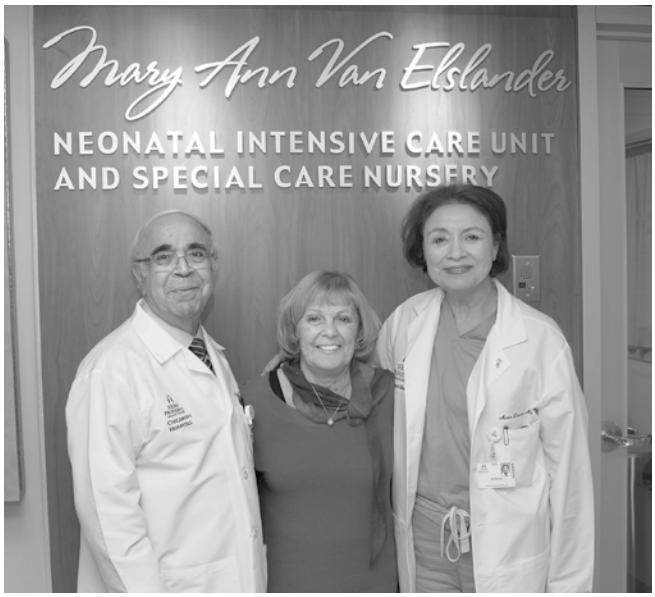
Pictured (l-r) Macomb County Sheriff Sargent Jeff Budzynowski, Chad Kovala, DO, John Floreno, DO, Sheriff Tony Wickersham, SJMOH President Terry Hamilton, and sheriff sergeant's Gary Wiegand and Aaron Horne.

RENOVATED AND EXPANDED NICU OPENS AT ST. JOHN HOSPITAL & MEDICAL CENTER

The newly renovated and expanded Mary Ann Van Elslander Neonatal Intensive Care Unit (NICU) and Special Care Nursery at St. John Hospital & Medical Center opened in late January. The redesigned unit provides the hospital's tiniest and critically ill infants with an enhanced care environment.



The new NICU is double the square footage of the previous unit and features: 32 private nurseries with additional space for multiples; overnight accommodations for family; state-of-the art equipment to better care for and foster growth and development of critically ill babies; reduced light and sound disturbances; and enhanced privacy and safety. The updated Special Care Nursery includes six spacious semi-private cubicles and two private rooms. In addition, an investment in technology was made including a state-of-the-art cardio-respiratory monitoring system, dual incubator/warmer beds, ventilators and a new infant security system. The $12 million project was funded through a capital investment of $7 million from St. John Providence and donations so far totaling $3.8 million from more than 600 associates, physicians, board and community members. The NICU staff cares for approximately 450 infants annually, including many transferred from other regional hospitals



The redesigned NICU is named for the Van Elslander family for their large philanthropic gift and for Mary Ann Van Elslander (pictured center), a long-time volunteer in the NICU. She is joined by Ali Rabbani, MD, retired Pediatrics chief, and Maria Duenas, MD, director, Mary Ann Van Elslander Neonatal Intensive Care Unit and Special Care Nursery.

throughout Michigan and southern Ontario. Babies as small as 1 pound are treated in St. John Hospital &Medical Center's NICU, and its survival rate is one of the highest in the world.

OUTCOMES FOR GASTROINTESTINAL CANCER PATIENTS TREATED AT ST. JOHN HOSPITAL & MEDICAL CENTER COMPARABLE TO TOP CANCER CENTERS

A new study shows that patients treated for a variety of gastrointestinal (GI) cancers at St. John Hospital & Medical Center receive a comparable multidisciplinary evaluation and treatment plan, and equivalent or superior oncological outcomes compared to patients who are treated at top medical institutions and cancer centers throughout the country. Over the past decade there has been a shift toward performing complex oncological resections of GI cancers, such as pancreatic, gastric, and colorectal cancer, at university institutions and National Cancer Institute-designated cancer centers. The St. John Hospital & Medical Center study found that complex oncologic resections can be safely performed at a community-based hospital with low patient morbidity and mortality results, if it is led by a well-organized, surgeon-led multidisciplinary team. The study involved the treatment of 224 patients over four years who underwent abdominal oncological resection by Richard M. Berri, MD, FACS, director of Surgical Oncology and Peritoneal Malignancies Program. There were no 0, 30, 60 or 90 day mortalities and the complication rate was 44 percent. The 1-, 2-, and 3-year survival rate of the entire group was 93 percent. Dr. Berri says that the St. John Hospital analysis is ground breaking on several fronts: the data is from a single hospital (instead of multiple sites), patients were treated by the same surgeon, and patient outcomes were tracked for 90 days instead of the typical 30 days.

NEW PEDIATRIC CHAIR FOR ST. JOHN HOSPITAL & MEDICAL CENTER APPOINTED

Muthayipalayam Thirumoorthi, MD, has been appointed the new chair of pediatrics at St. John Hospital & Medical Center. Dr. Thirumoorthi joined the staff of St. John Hospital in February 1988, and has held several positions of leadership, including interim chair of pediatrics and section chief of the pediatric infectious disease division. He is on the faculty of the Wayne State Department of Pediatrics and is a diplomate of the American Board of Pediatrics.

SCAR-LESS TREATMENT FOR ESOPHAGEAL ACHALASIA

A scar-less procedure aimed at restoring swallowing function in patients with achalasia, a rare, debilitating condition where the esophagus is unable to move food into the stomach, is being offered at St. John Hospital & Medical Center. More than 3,000 people are diagnosed with esophageal achalasia each year. St. John Hospital & Medical Center interventional gastroenterologist and chief of gastroenterology, Mohammed Barawi, MD, was one of the first in the state to perform the procedure and the hospital is one of only a handful of institutions in the U.S. treating patients with the scar-less procedure. This specialized treatment method is even less invasive than laparoscopic surgery and means faster recovery for the patient.

CRANIOFACIAL INSTITUTE OF MICHIGAN RELOCATES TO ST. JOHN PROVIDENCE CHILDREN'S HOSPITAL

In early January the Craniofacial Institute of Michigan relocated to St. John Providence Children's Hospital at St. John Hospital & Medical Center. The institute performs simple procedures to highly complex surgeries for pediatric and adult patients with cleft and other craniofacial conditions. While all of the institute's multidisciplinary team meetings and cleft and craniofacial reconstructive surgical procedures will occur at St. John Hospital & Medical Center, the practice will continue to see patients and provide consultation and follow-up care from its outpatient offices in Dearborn and Novi.

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.

Telemedicine as a Growing Practice Model

By: Til Jolly, MD, The Doctors Company

HEALTHCARE IN THE UNITED STATES IS OFTEN COMPROMISED BY FRAGMENTATION IN ITS DELIVERY, LIMITED PATIENT ACCESS DUE TO A SHORTAGE OF PRIMARY CARE DOCTORS, LONG WAIT TIMES (EVEN FOR PATIENTS WHO HAVE APPOINTMENTS), AND SPIRALING COSTS.[1] As a result, innovative approaches to delivering healthcare are becoming increasingly important in America's continued pursuit of improved outcomes and reduced cost of care.

Healthcare delivery models such as telemedicine aim to address the long wait times and high administrative costs associated with traditional care and offer important insights for improving the healthcare process.

By definition, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.[2] Although telemedicine is rapidly expanding, it is a concept that has existed for more than half a century. At its basic level, telemedicine is a physician talking on the phone to a patient or another physician. Today, the term telemedicine includes remote physician consultations through channels such as texting, video, e-mail, and other wireless tools.[2] Ultimately, the goal is to connect a physician with a patient to provide a diagnosis and recommend treatment options.

The U.S. population is getting older and more patients are dealing with chronic conditions. The result is an increasing demand for care. Unfortunately, communities across the country are simultaneously experiencing physician shortages. The Association of American Medical Colleges estimates that the U.S. will face a shortage of more than 130,600 physicians by 2025.[3] The use of telemedicine has the potential to provide some relief from this shortage, which is expected to be equally distributed among primary care and medical specialties such as general surgery, cardiology, and oncology.

Telemedicine can be a cost-effective way to monitor patients, promote better health habits, and provide patients with access to healthcare professionals beyond the walls of their local hospitals and health practices. Telemedicine can help with urgent requests to see a physician as well as more routine follow-up appointments and visits specifically for prescription refills.

Although telemedicine has a lot to offer America's health system, physicians must carefully consider when to incorporate it into the continuum of care. According to The Doctors Company, the nation's largest physician-owned medical malpractice insurer, the following are some potential risks providers should be aware of:

- **Telemedicine can pose challenges for the traditional physician-patient relationship.** Office visits allow time for conversations that build relationships and have a positive impact on care. Personal relationships matter in healthcare, and patients need engaged care providers to become engaged themselves. Done properly, telemedicine provides connection, communication, and continuity that can enhance patient care and the physician-patient relationship. Consider developing strategies to ensure patients understand how telemedicine improves their medical care.
- **A physician cannot perform the onsite portions of a physical exam.** Not having a physician on-site to perform a physical examination can mean inaccuracies from patient self-reporting and missing additional findings that may only be caught in person. These risks should be communicated to the patient and documented very clearly in the medical record. In some settings, local onsite support personnel can be part of a complete telemedicine program. The literature increasingly supports inclusion of telemedicine in many practice settings.
- **Telemedicine is very dependent on technology.** It relies on equipment like examination cameras, remote monitoring devices, and surgical robots. If the equipment is inoperable, patient safety and health are at risk. Faulty technology or equipment may cause a physician to act on inaccurate information or prevent the physician from facilitating adequate or continuous care.
- **Be aware of privacy, security, and patient confidentiality.** It's important to remain HIPAA-compliant. Physicians interested in integrating telemedicine into their practices should ensure patient data files are encrypted to prevent a data breach or cyberattack, clearly define proper protocol for webcams and web-based portals, and ensure there is a mechanism in place to protect the privacy of individuals - including staff members, other patients, or patients' families - who do not want to be videotaped if sessions are being recorded.

Managing the social aspects of telemedicine can be challenging, but telemedicine has the potential to support a stressed delivery system by increasing patient access to care, improving outcomes, and reducing healthcare costs.

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[2] Measles. Travelers' Health. Centers for Disease Control and Prevention. http://wwwnc.cdc.gov/travel/diseases/measles. Published May 9, 2013. Updated December 13, 2013. Accessed June 5, 2014.

[3] Middle East Respiratory Syndrome (MERS): Healthcare Provider Preparedness Checklist for MERS-CoV. Center for Disease Control and Prevention. http://www.cdc.gov/coronavirus/mers/preparedness/checklist-provider-preparedness.html. Published July 15, 2013. Accessed June 5, 2014.

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THE DOCTORS COMPANY

New Members

RANDALL R. COLVIN, MD
Family Practice - Board Certified

Medical School: St. George's University, 2011. Internship & Residency: St. John Hospital & Medical Center, completed in 2014. Hospital Affiliation: St. John Hospital & Medical Center. Currently practicing at Bay Area Family Physicians, 34301 23 Mile Rd., Ste. 100, New Baltimore, MI 48047, ph. 586-725-1770, fx. 586-725-4080.

RAMESHBHAI M. PATEL, MD - Transfer from Wayne County
Internal Medicine - Board Certified

Medical School: BJ Medical College Gujarat Univ. (India), 1973. Internship & Residency: Interfaith Medical Center (NY). Hospital Affiliation: St. John Macomb-Oakland. Currently practicing at Samaritan Urgent Care, 5575 Conner St., Detroit, MI 48213, ph. 313-924-0000.

ELENN'L ELNESS, MD - Transfer from Wayne County
Family Practice - Board Certified

Medical School: Univ. of Minnesota, 1985. Internship & Residency: North Memorial Medical Center (MN). Hospital Affiliation: Henry Ford Macomb. Currently practicing at Henry Ford Macomb Urgent Care, 15717 15 Mile Rd., Clinton Twp., MI 48035, ph. 586-285-3850 and Livonia Urgent Care, 37595 Seven Mile Rd., Livonia, MI 48185, ph. 734-542-6100.

Letters of Thanks

February 3, 2015

Dear Supporters,

On behalf of the Macomb Food Program and its Board of Directors, we would like to extend a sincere "thank you" for your generous donation of $2,760 to the Macomb Food program.

The Macomb Food Program serves people in need of food throughout the County of Macomb through its network of 52 pantry distribution sites. Every dollar donated is used to purchase food to help feed hungry families, children, the elderly and disabled throughout Macomb County. Last year, with the help of generous donors, we were able to feed nearly 500 people per day!

Your generosity allows the Macomb Food Program to continue to make feeding the hungry in Macomb County a reality. Thank you again for your donation and your generous support for our mission to feed the hungry in Macomb County.

Gratefully,
Michael Sheridan, Chairperson
Macomb Food Program

Linda Azar
Food Program Coordinator

February 3, 2015

Dear MCMS Foundation,

On behalf of everyone here at Turning Point, we thank the Macomb County Medical Society Foundation for your ongoing support to our mission to end domestic and sexual violence! We very much appreciate the gift from the Macomb County Medical Society Foundation of $3,490 from your Holiday Sharing Card Project.

The Foundation's ongoing emergency, support and prevention services continue to be available in our community! Each day, we provide the basic need for safety and hope to up to 52 women and children in our shelter. Your continued generosity supports life-saving services to thousands of women and their children coping with the effects of violence through our 24-hour crisis hotline, emergency shelter, Forensic Nurse Examiner program, legal advocacy, support groups and counseling programs. We would be unable to meet these challenges without the continued support of our community. We thank everyone at the MCMS Foundation for their many years of support and interest in our mission.

Thank you all for your generosity.

Sincerely,
Suzanne Coats, President and CEO
Turning Point Inc.

Get Involved with Your Medical Society!

We need Members to Participate on MCMS Committees

WE WANT VOLUNTEERS WILLING TO ATTEND AND ACTIVELY PARTICIPATE ON COMMITTEES. If you are interested in being on one of the following committees please email Heidi Leach at the MCMS office at mcms@msms.org or call 810-387-0364.

MACOMB COUNTY MEDICAL SOCIETY STANDING COMMITTEES:

BYLAWS – meets as needed to consider amendments to the MCMS Bylaws.

ETHICS & MEDIATION – meets as needed concerning the maintenance of standards of conduct and discipline of members as well as to review patient complaints.

LEGISLATIVE & SOCIAL ECONOMICS – meets quarterly with local and state legislators on Fridays at 7:30 am at the Loon River Café in Sterling Heights.

MEMBERSHIP – meets as needed to promote recruitment of non-members and to ensure retention of current members.

PROGRAM – meets as needed to plan and organize the regular meetings, special events, and fund raisers for the Society and the Foundation.

PUBLIC RELATIONS – meets as needed with community organizers and businesses to accurately convey medicine's message to the public sector.

ANNOUNCEMENTS

MARCH 25 Free MSMS Webinar, "Patient Portals as a Tool for Patient Engagement", 12:15 pm - 1:15 pm. No cost, but registration is required, to register visit www.msms.org/Education.

APRIL 22 Free MSMS Webinar, "Preparing for the Medicare Physician Value-based Payment Modifier", 12:15 pm - 1:00 pm. No cost, but registration is required, to register visit www.msms.org/Education.

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

MAY 13-14 MSMS 4th Annual Spring Scientific Meeting, The Henry in Dearborn. To register visit www.msms.org/Education or call 517-336-7581

MAY 14 Free CME opportunity. "Extended-Release and Long-Acting Opioid REMS: Achieving Safe Use While Improving Patient Care", The Henry in Dearborn, 9 am - 12:15 pm. To register visit www.msms.org/Education or call 517-336-7581.

MAY 14 54th Annual Joseph S. Moore, MD, Conference on Maternal & Perinatal Health, The Henry in Dearborn, 9 am - 4:15 pm. To register visit www.msms.org/Education or call 517-336-7581

MAY 20 Free MSMS Webinar, "What's New in Labor and Employment Law", 12:15 pm - 1:00 pm. No cost, but registration is required, to register visit www.msms.org/Education.

JUNE 10 Free MSMS Webinar, "Health Care Providers' Role in Screening and Counseling for Interpersonal and Domestic Violence: Dilemmas and Opportunities", 12:15 pm - 1:00 pm. No cost, but registration is required, to register visit www.msms.org/Education.

OCTOBER 21 Free CME opportunity. "Extended-Release and Long-Acting Opioid REMS: Achieving Safe Use While Improving Patient Care", Somerset Inn in Troy, 5:15 pm - 7:30 pm. To register visit www.msms.org/Education or call 517-336-7581

NOVEMBER 17 MCMS Annual Meeting.

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.

TOP 10 ISSUES FOR PHYSICIANS TO WATCH IN 2015

The year ahead promises many changes and challenges for the medical profession. From taking on regulatory burdens to improving health outcomes for patients, 10 of the top issues physicians should monitor in the year ahead encompass the broad spectrum of today's medical practice.

1. The administrative load and competing regulatory programs. Studies show that one of the greatest frustrations to physicians is the time and expense they must devote to administrative and regulatory requirements, pulling time away from patient care without a direct benefit to care delivery or health outcomes.

In 2015, the AMA will intensify efforts to reduce barriers to providing high-quality care, including:

- Electronic health records (EHR) and meaningful use. At the top of many physicians' lists of things that need to change are unhelpful EHR systems and unachievable meaningful use requirements. According to data the Centers for Medicare & Medicaid Services (CMS) released in mid-December, more than 50 percent of eligible professionals will face payment penalties next year because they could not fulfill meaningful use requirements.

  The AMA will continue to push for the adoption of solutions to the one-size-fits all meaningful use program, as outlined in a blueprint submitted to CMS in October.

  In addition, the AMA is building on a new framework for EHR usability that it developed with an external advisory committee of practicing physicians and health IT experts, researchers and executives. The AMA is working with physicians, EHR vendors, policymakers, health care systems and researchers to drive EHR improvements that can advance the delivery of high-quality, affordable care.

- ICD-10 implementation. The AMA has advocated for end-to-end testing, which will take place between January and March and should provide insight on potential disruptions from ICD-10 implementation, currently scheduled for Oct. 1.

  Given the potential that policymakers may not approve further delays, ICD-10 resources can help physician practices ensure they are prepared for implementation of the new code set.

- Federal fraud and abuse programs. While preventing unscrupulous activities in the Medicare system is an appropriate goal, many physicians are being unduly taxed by the "bounty-hunter" efforts of the Medicare recovery audit contractors (RAC). In fact, more than 60 percent of RAC determinations are overturned when appealed. Meanwhile, CMS has a two-year backlog of appeals to sort through. The AMA will continue to push the agency to overhaul this program in the year ahead.

2. The Medicare physician payment system. Congress will need to act early this year to avoid a 21 percent pay cut scheduled to take effect April 1 under the sustainable growth rate (SGR) formula. Because Congress missed its opportunity last year to repeal the SGR formula using a bipartisan legislative framework, the AMA and physicians will continue communicating with lawmakers - including those newly elected - to make reforming the Medicare payment system a priority for the new Congress.

In addition to addressing the SGR formula, the AMA will be tackling other timely issues related to the Medicare fee schedule, including the value-based payment modifier, elimination of the global surgical period and potentially misvalued codes.

3. Adequate provider networks. The current trend toward very limited provider networks has necessitated physician action to ensure patients have access to the care they need. The AMA is bolstering its national- and state-level efforts to make sure health insurers are required to maintain adequate networks, provide timely information about the physicians and other providers to whom patients will have in-network access, and comply with all laws and regulations.

4. Prescription drug abuse and overdose. Most stakeholders now agree that the nation's prescription drug overdose epidemic should be addressed primarily through treatment, prevention and education rather than law enforcement. But much work remains to execute solutions in local communities. The AMA will continue to lead policy development on this issue in the states and nationally, and engage physicians in practical activities to prevent prescription drug abuse and allow pain management for patients who need it.

5. Preventing type 2 diabetes and heart disease. As two of the nation's most troubling diseases, these chronic conditions have been targeted for elimination before they develop in patients. Physicians can expect to see practical resources to help prevent diabetes among their at-risk patients and tools to help improve blood pressure control among hypertensive patients throughout the year ahead. Such resources have been under development with physician pilot sites and national partners in the AMA's Improving Health Outcomes initiative.

6. Advances in clinical knowledge and information sharing. New medical information, treatments and technologies continue to evolve at an astounding rate. Staying on top of the latest knowledge and developments will be more important than ever this year.

The JAMA Network continues to find ways of helping physicians keep up with clinical knowledge, including a new journal that will debut early this year: JAMA Oncology.

7. Transformation of medical education. Medical schools that are part of a special consortium of the AMA's Accelerating Change in Medical Education initiative have been driving undergraduate medical education into the future by developing and implementing innovative ideas for medical student training. This work will continue to advance over the next year, and new schools will be adopting the best practices they are putting forward. Additionally, the initiative will be working toward changes in graduate medical education to improve physician education across the learning continuum.

8. Modernization of the AMA Code of Medical Ethics. This 167-year-old standard for the medical profession has been undergoing a comprehensive update for the past six years, and 2014 was spent soliciting and reviewing physician feedback on the proposed changes. A draft to be considered for adoption will be released this year.

9. Improved professional satisfaction and sustainability of practices. Physicians will have access to tools currently in beta testing that will help them address common clinical challenges so they can boost their professional satisfaction and the quality of their patient care. Part of the AMA's Professional Satisfaction and Practice Sustainability initiative, the tools will offer proven practice solutions, such as pre-visit planning, synchronized prescription renewals and collaborative documentation.

10. Court rulings on critical health care issues. Given the number of court cases that have made it to the Supreme Court of the United States and state supreme courts over the last few years, physicians can expect that the nation's courts will continue to play a crucial role in the practice of medicine. Topics of greatest importance continue to be the patient-physician relationship, medical liability and patient privacy.

An especially important case heard by the U.S. Supreme Court several months ago should be decided early this year. The decision will determine whether state health care licensure boards will retain their authority to regulate their health care professions to shield patients from potentially unlawful practice. The Litigation Center of the AMA and State Medical Societies will continue to ensure the physician's voice is heard in these cases.

DUTY-HOUR LIMITS HAVE NO EFFECT ON PATIENT OUTCOMES: NEW STUDIES

The 2011 limits placed on resident duty hours appear to have had no effect on patient deaths, patient outcomes or residents' examination performance, according to two studies published in the December 2014 JAMA.

After setting an 80-hour work week limit for residents in 2003, the Accreditation Council for Graduate Medical Education (ACGME) further restricted residents' work hours in 2011, including:

- Limiting first-year residents to 16 hours of continuous in-hospital duty
- Requiring that residents have at least 8 hours free between shifts
- Providing residents in-house for 24 hours with up to 4 hours for transfer of care activities and requiring at least 14 hours off between shifts

In one study - one of the first national empirical evaluations of the ACGME's 2011 duty hour reform - researchers found no association with a change in surgical patient outcomes or resident examination performance after comparing data from teaching and nonteaching hospitals in the two years before and after reforms were implemented.

"This could indicate that current policies should continue forward as they are," the study said. "Conversely, the potential harm from poor continuity of care, increased handoffs, trainees feeling unprepared to practice and concern regarding residents developing a shift-work mentality engendered by these policies could suggest that duty-hour reform may require significant revision or reconsideration."

The other study found no significant differences in 30-day mortality or readmission rates after analyzing nearly 6.4 million admissions, including almost 2.8 million Medicare patients at 3,104 hospitals in the two years before and the first year after reform. The study is one of the first national evaluations of association between the 2011 duty-hour reform and patient outcomes.

AMA policy supports duty-hour research to explore a variety of issues, including patient safety, preparedness for practice, workload and patient volume, handoffs, and professionalism. A report from the AMA Council on Medical Education encourages the study of innovative models of duty-hour requirements, including potentially creating specialty- or rotation-specific duty-hour requirements that would optimize competency-based learning opportunities.

In March, the ACGME announced it would waive certain duty-hour standards for two large, national, multi-institutional resident trials. The core standards of 80-hour work weeks (averaged over four weeks), one day off for every seven worked (averaged over four weeks) and call no more frequently than every third night will remain in place for both trials.

The AMA supports the ACGME in its duty-hours investigation and is urging the ACGME to continue offering residency program incentives to ensure compliance

with the standards, meeting with peer-selected or randomly selected residents during site visits, and collecting and sharing data on at-home call.

PHYSICIANS PUSH ELECTRONIC HEALTH RECORD INTEROPERABILITY

The AMA, along with 36 other physician groups, drafted and sent a letter to the Office of the National Coordinator for Health Information Technology (ONC) pertaining to some of the many issues surrounding electronic health records (EHR) and their certification. Certified EHRs are required for physicians to participate in the meaningful use program.

The usability, interoperability and safe use of EHRs can be improved in the short term while helping to guide further efforts by ONC and EHR vendors in the long term. The letter addresses three key issues:

- **Usability.** The method used to test EHR usability is underdeveloped, and testing often does not mimic real-world medical practice. More rigorous testing to include a variety of different scenarios, including test cases that represent the needs of medical specialists, would help to improve how the technology is used in real-life workflows.
- **Interoperability.** The act of two computers sending and receiving data does not constitute functional interoperabilityóthe ability for information to be exchanged, incorporated and presented to a physician in a contextual and meaningful manner. Efforts should be placed on ensuring the necessary health information follows patients during transitions of care.
- **Security.** Protecting the privacy and security of patient information is crucial, yet current methods for accessing data, like passwords and tokens, are cumbersome and can still be compromised. Health IT regulators and EHR vendors should look toward advancements in consumer electronics and develop identification solutions to reduce many of the authentication difficulties medical professionals face.

For more information on the AMA's advocacy on health IT, visit the AMA website at www.ama-assn.org. You can also access the 166-page draft Interoperability Roadmap published by ONC on Jan. 30 at www.healthit.gov/policy-researchers-implementers/interoperability. The AMA will share more information shortly and seek feedback from the Federation. Comments are due to ONC on April 3.

ICD-10 2014 Year in Review

2014 was a challenging year for ICD-10 preparation. In the first quarter of 2014, as the Healthcare Industry readied for an October 1, 2014 compliance deadline, the Industry was alerted that Congress passed a Bill in March to delay ICD-10 implementation. This announcement left the Healthcare Industry contemplating how to move forward with ICD-10 planning.

As the Industry attempted to realign their focus and strategic plans with the delay in ICD-10 implementation, MDCH's message to providers and internal and external stakeholders remained the same: "Stay the course! Continue to plan as scheduled. The additional time provided by the delay should be viewed as an advantage and should be utilized accordingly." MDCH Provider Outreach moved forward with plans to produce informational webcasts, training modules, and provide testing opportunities to providers, vendors, and trading partners. After CMS announced the official implementation deadline of October 1, 2015, additional ICD-10 virtual trainings to providers were offered.

MDCH's goals for 2015 is the continuation of providing ICD-10 resources to internal associates, providers, and external stakeholders. Please visit our website for the latest ICD-10 information.

2014 Year in Review:

Industry Wide ICD-10 Synopsis

1. **March 2014**: Congress approved the "Protecting Access to Medicare Act of 2014." This Bill:

   - Prevented a significant decrease in Medicare payments scheduled for March 31.
   - Delayed scheduled Medicaid cuts to hospitals serving low-income patients.
   - Changed the ICD-10 implementation date by at least one year from to October 1, 2014 to October 1, 2015.
   - Signed into Law by President of the United States on April 1, 2014.

2. **July 31, 2014**: CMS officially announced ICD-10 implementation delay as October 1, 2015.

   - New Deadline for ICD-10 allows Health Care Industry additional time to prepare for change.
   - Press Release.

3. **September 22, 2014:** WEDI (Workgroup for Electronic Data Interchange), the nation's leading nonprofit authority on the use of health IT to create efficiencies in healthcare

information exchange, announced the release of it findings from the August 2014 Readiness Survey**.**

- **The following statement was released from WEDI:** "Based on the survey results, all industry segments appear to have made some progress since October 2013, but the lack of progress by providers, in particular smaller ones, remains a cause for concern as we move toward the compliance deadline. Delaying compliance efforts reduces the time available for adequate testing, increasing the chances of unanticipated impacts to production. We urge the industry to accelerate implementation efforts in order to avoid disruption on Oct. 1, 2015" - *Jim Daley, WEDI chairman and ICD-10 Workgroup co-chair.*
- Vendors and health plans continue to make progress. Although testing and other tasks are being pushed to 2015, providers show lack of progress from the October 2013 survey.
- WEDI will continue its efforts to move the industry forward and plans to continue its surveys to gauge industry readiness.
- Full survey results can be found at: WEDI News/ ICD-10 Industry Readiness Survey.

2015 MDCH ICD-10 Provider Testing

Now that ICD-10 Implementation planning is underway for a compliance deadline of October 1, 2015, providers should focus on testing their systems in order to ensure that ICD-10 claims will adjudicate appropriately. MDCH has offered the following testing opportunities for providers and trading partners:

1. **Outpatient Scenario-Based Testing**
2. **Inpatient DRG Comparative Testing**
3. **Business-to-Business (B2B) Testing**

For more information regarding Testing, please visit our website. Click Testing Button In MDCH Links. For testing questions, please e-mail MDCH-B2B-Testing@michigan.gov.

How Can We Help? – ICD-10 Resources

MDCH	**www.michigan.gov/5010icd10 "click" ICD-10 button**
CMS	**www.cms.gov/icd10**
AHIMA	**www.ahima.org**

MICHELLE C. MILES
MDCH PROVIDER LIAISON, ICD-10 AWARENESS & TRAINING PROJECT LEAD
EMAIL MDCH-ICD-10@MICHIGAN.GOV

Having Reimbursement Problems? Need Coding Assistance?

MSMS would like you to meet the solution to your reimbursement and coding problems. With more than 20 years of experience in physician billing issues, Stacie Saylor is the MSMS Reimbursement Advocate. She holds credentials as a Certified Professional Coder (CPC) and Certified Professional Biller (CPB). As the MSMS Reimbursement Advocate, (free member resource) she has direct contacts with every health plan in the state and can help recover difficult delayed payments. The MSMS Reimbursement Advocate has helped thousands of MSMS physicians recover as little as $30, and as much as $50,000.

In addition, she can provide help on clarifying the appropriate use of codes or modifiers for billing insurance companies. You have the peace of mind knowing that your coding practices are up-to-date and appropriate for the level of care delivered.

If you are having coding or reimbursement problems, and you or your physician is a member of MSMS, contact Stacie Saylor at MSMS: 517.336.5722 or ssaylor@msms.org.

Great Opportunity for a Retired or Semi-Retired Medical Professional

Northwood

Specialized health benefits manager located in Detroit suburb seeks part time physician (board certified M.D. or D.O. with a current, valid, unrestricted medical license) for medical reviews of requests for durable medical equipment, medical supplies, orthotic and prosthetic devices. Reviews will be coordinated with existing support staff who compile necessary medical documentation for each case. Daily, flexible hours. Great opportunity for a retired or semi-retired medical professional.

If you would be interested in learning more about this opportunity, please contact Northwood's Chief Operating Officer, Lisa Wojno at 586-755-3830; ext. 3727

PROM

PROM Seeks Specialists to Serve as Peer Reviewers

Physician's Review Organization of Michigan (PROM) is seeking peer reviewers in all specialty fields. The increased necessity for independent peer review has required PROM to search for additional specialists to assist in providing high quality peer reviews.

Since its founding in 1983 by the Michigan State Medical Society and Michigan Osteopathic Association, PROM has provided case reviews to a wide range of groups including hospitals, physician practices, managed care organizations, and major insurance companies.

PROM has a peer review panel of more than 250 physicians and allied health professionals in a variety of specialties to ensure its clients receive informed, confidential, and objective reviews. PROM is fully accredited by the American Accreditation Health Care Commission (URAC).

If you are interested in becoming a reviewer, please contact Mirya Brion at 517-336-1442, (800) 722-5392 or MBrion@PhysiciansReviewOrganization.com.

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

	2014	2013	2012
AIDS	53	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	85	68**	118**
CHICKENPOX	88	40**	46**
CHLAMYDIA	2,407	2,514	2,393
COCCIDIOIDOMYCOSIS	7	2	2
CREUTZFELDT JAKOB	2	1	0
CRYPTOCOCCOSIS	2	1	6
CRYPTOSPORIDIOSIS	9	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	28,824	42,989	36,172
GIARDIASIS	20	19	24
GONORRHEA	481	575	530
GRANULOMA INGUINALE	0	0	0
GUILLAIN-BARRE SYNDROME	6	8**	5**
HEMOLYTIC UREMIC SYN.	0	0	0
HEPATITIS A	4	7	1
HEPATITIS B (ACUTE)	7	7	4
HEPATITIS B (CHRONIC)	153	123**	152**
HEPATITIS C (ACUTE)	15	7	6
HEPATITIS C (CHRONIC)	698	494**	598**
HEPATITIS D	0	0	1
HEPATITIS E	0	0	3
H. FLU INVASIVE DISEASE	9	11	8
HISTOPLASMOSIS	3	3**	7**
INFLUENZA, NOVEL	0	0	0
KAWASAKI SYNDROME	5	9	6
LEGIONNAIRE'S DISEASE	24	31	15

	2014	2013	2012
LISTERIOSIS	1	1	1
LYME DISEASE	1	0	0
MALARIA	1	0	4
MEASLES	0	0	0
MENINGITIS VIRAL	44	75**	75**
MENINGITIS BACTERIAL/BACTEREMIA (EXCLUDING N. MENINGITIDIS)	8	4	6
MENINGOCOCCAL DISEASE	1	0	0
MUMPS	2	0	0
PERTUSSIS	81	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	75	76**	95
SHIGELLOSIS	9	4	10
STEC***	12	6	6
STREP INVASIVE DISEASE	26	18	9
STREP PNEUMO INV DS	44	58	41
SYPHILIS	43	78	55
SYPHILIS CONGENITAL	0	1	3
TETANUS	0	0	0
TOXIC SHOCK SYNDROME	1	2	0
TUBERCULOSIS	10	11	9
TULAREMIA	0	0	0
TYPHOID FEVER	1	0	0
VIBRIOSIS	0	0	
VISA	1	2	0
WEST NILE VIRUS	0	3**	28**
YERSINIA ENTERITIS	3	0	0

All 2014 numbers remain provisional

**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

March/April 2015
Index of Display Advertisers

Medical Records of Retired Physicians

Patients looking for their medical records from retired physicians frequently contact the MCMS. If you are retired or will be retiring shortly, please contact the MCMS at 810-387-0364 or email mcms@msms.org and let us know how patients can retrieve their records. If the records have been destroyed, please inform us of that also so we can note our database accordingly. Thank you!

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