Macomb

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Macomb Medicus

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Our Crumbling Infrastructure

By: Daniel M. Ryan, MD

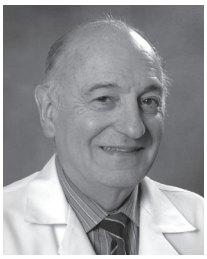
"FIX THE ---- ROADS." That campaign slogan of Governor Gretchen Whitmer is beginning to resonate more as street potholes are increasing in number and size with the fluctuating temperature and weather changes. The Governor and Macomb County Drain Commissioner Candice Miller have noted the poor status of our state's and county's infrastructure. Michigan received a D minus grade on road conditions by the American Society of engineers and a D plus regarding infrastructure. Our transportation systems, pipes and sewer systems, and framework to use computers and cellular networks are all in need of significant repair. In 2016, a sink hole the size of three homes occurred due to a pipe collapsing below the road in Fraser, Macomb County. Multiple cities in Michigan have issues with lead pipes leading to contamination of drinking water.

It is estimated that the renovation of Michigan's infrastructure will cost citizens billions of dollars. As politicians debate whether to fund these repairs by increasing taxes, such as the Governor's previously proposed 45 cent tax on a gallon of gas, or to borrow money from pension funds as proposed by some state congressional leaders, or use bonds per the Governor's most recent plan, the situation of an aging structural foundation continues to get worse.

The healthcare industry will need to be prepared to deal with medical conditions as a result of an infrastructure catastrophe. These include possible patient surges and managing mass fatalities and unforeseen related health issues if one is to occur. Medical organizations can reduce patient risk by being prepared and having emergency action plans. Hospital systems will have to balance potential strain on their systems with an increased demand of services, HIPAA compliance issues, and making sure they remain operational during a potential disaster.

Physicians will have to make ethical decisions including when to treat, who gets treated first, who gets the limited resources, and of course, potential liability issues if a physician/patient relationship is considered established. The development of procedures by hospital organizations and physician groups will be an ongoing challenge to face unsuspected morbidities from infrastructure disasters that must be met. There will be medical consequences as a result of Michigan's and Macomb County's infrastructure disrepair. Future disasters in Macomb County, in addition to those related to sink holes and rising water levels of Lake St Clair, will inevitably occur. We must support the state and county to invest in the structural foundation of the economic framework, and encourage our hospital and healthcare systems to update action plans as assessment of the foundation improves. Finally, as physicians we must be prepared to maintain our Hippocratic Oath and honor and care for our patients even if the ---- roads don't get fixed.

MSMS BOARD OF DIRECTORS MEET, DISCUSS PRIOR AUTHORIZATION, TEAM-BASED CARE



By: Adrian J. Christie, MD; Paul Bozyk, MD; Donald R. Peven, MD;

During the January 29, 2020 meeting of the Michigan State Medical Society (MSMS) Board of Directors, the Board discussed the latest information in regards to Health Can't Wait, a coalition of patients, physicians, and health care providers dedicated to putting Michigan patients first and ending delays in patients' access to health care, and an initiative to team-based care.

HEALTH CAN'T WAIT

Michigan patients would be one step closer to the timely care and treatment they need with action from members of the state Senate Health Policy and Human Services Committee, who, on Thursday, heard testimony from physicians, patients, and patient advocates on legislation that reforms prior authorization and step therapy practices - policies insurance companies use to slow - and sometimes deny - life saving health care.

Patients, physicians and advocates including S. Bobby Mukkamala, MD, president-elect of the Michigan State Medical Society testified in support of Senate Bill 612, the Health Can't Wait Act. The bill is sponsored by state Sen. Curt VanderWall, who serves as chairman of the Senate Health Policy and Human Services committee.

The Health Can't Wait Act would introduce new transparency, clinical validity and fairness requirements to prior authorization and step therapy practices, empowering physicians to override step therapy protocols when they consider it not to be in a patient's best interest. The act would also require insurers to base their prior authorization requirements on clinical, evidence-based criteria established with input from practicing physicians.

The Health Can't Wait Act would also establish:

- Transparency - Insurance company prior authorization requirements will be published on the insurer's website in detail and in easily understandable language.
- Clinical validity - Adverse determinations and decisions on appeals must be made by a physician in the same specialty as the service being requested. Medical directors of insurance companies must be licensed to practice medicine
- Fairness for patients - Urgent and non-urgent prior authorization requests must be acted upon by insurers within 24 and 48 hours, respectively.

Please visit http://HealthCantWait.org to write your lawmakers to support Senate Bill 612 and learn more.

TEAM-BASED CARE

MSMS embarked on a project to explore the intersection of scope of practice laws as they relate to team-based care. Although originally intended to focus on role clarity within physician-led health care teams, but the focus quickly shifted to the potential for high-functioning, physician-led teams to impact physician wellness and achieve the Quadruple Aim of improved patient care, lower costs, better outcomes, and clinician satisfaction. Supporting this shift in thinking was the recognition that value-based reimbursement, population health measurement, increased administrative hassles and duties, workforce shortages, and patients with increasingly complex needs are driving the need for effective team-based care.

The committee, which consisted of members from MSMS's Committee on Health Care Quality, Efficiency, and Economics chaired by John E. Billi, MD, (Washtenaw), developed a plan to help physicians foster high-functioning teams by utilizing MSMS's communication channels, relationships with other stakeholders, and ability to create resources for members. Examples of activities include identifying high-functioning teams, communicating best practices and lessons learned, creating a resource library, and pursuing opportunities to participate in pilot projects such as the American Medical Association's and Physician Foundation's Practice Transformation Initiative.

The next step is to begin the creation of a task force that will develop a timeline for rollout and implementation strategy. If you are interested in being a part of the team-based care initiative, please contact Stacey Hettiger.

PHYSICIANS AND PATIENTS TELL LEGISLATIVE COMMITTEE THAT HEALTH CAN'T WAIT

The Senate Health Policy and Human Services Committee heard testimony from physicians, patients and patient advocates on Senate Bill 612. The first hearing lasted for over two hours, resulting in a need for additional hearings.

Thursday, January 31, 2020. More than 150 Health Can't Wait advocates, easily identified by HCW buttons and yellow clothing and accessories, filled the Senate hearing room and two overflow rooms. MSMS President-Elect Bobby Mukkamala, MD, was the first to testify, later followed by Jerome Seid, MD, and Irene Kazmers, MD. Each physician brought a patient to speak with

them. Physicians educated the Committee about the increased staff time and cost associated with prior authorization processes, and each patient gave a compelling testimony about how prior authorization and step therapy has affected their lives, especially the delays in care and amount of time they spend to obtain a prior authorization. The Senators also heard from the opposition including the Economic Alliance of Michigan and Blue Cross Blue Shield of Michigan.

Thursday, February 6, 2020. The Committee held a second hearing that included more input from health plans that oppose the bill, including the Michigan Association of Health Plans, Blue Cross Blue Shield of Michigan and GM. Testimony from Health Can't Wait supporters included Kathy Jo Uecker, from the Michigan Medical Group Management Association; Dennis Ramus, MD, President of The Physician Alliance; and Harold Moores, MD. Ms. Uecker gave her perspective about how prior authorization and step therapy affect day-to-day practice operations. Doctor Ramus talked about the death of one of his patients after a delayed prior authorization. Finally, Doctor Moores, an ER physician, spoke about patient abandonment and how it drives up emergency department costs. The full testimony is available at https://misenate.viebit.com/player.php?hash=ZTSiKhEGyziN.

The Committee will have another hearing next week. We will be coordinating additional testimony from the coalition, and continue to meet with committee members and legislative leadership to reinforce the points made in testimony.

SARAH WAUN JOINS MICHIGAN STATE MEDICAL SOCIETY

On January 29, 2020 the Michigan State Medical Society (MSMS) announced the addition of Sarah Waun as their director of state and federal government relations.

Waun comes to MSMS from the Michigan State Senate where she served as a policy advisor on health care issues under Senate Majority Leaders Mike Shirkey and Arlen Meekhof. In addition, she served as a budget advisor on the Department of Health and Human Services budget and previously was a legislative aide to former state Senator Roger Kahn, MD.

"Sarah has spent her career dedicated to improving health care outcomes for Michigan residents, "said Michigan State Medical Society CEO Julie Novak. "We are excited to have her extensive legislative experience at MSMS and know she will be an asset to physician and patient advocacy."

Waun earned a bachelor's degree in political theory and constitutional democracy from the James Madison College at Michigan State University.

PREVENTING DEATH FOLLOWING SURGICAL COMPLICATIONS

A new issue brief, titled "Better care for surgical patients: Recognizing and responding to the unexpected to save lives," from the University of Michigan (U-M) Institute for Healthcare Policy & Innovation (IHPI) outlines key takeaways around how health care systems can prevent deaths following a major post-surgical complication (referred to as ëfailure to rescue'), and details the implications for policy and practice.

Through a project called MRescue, a team at U-M is working to develop and evaluate tools aimed at improving rescue after postsurgical complications that could be applicable across hospital settings. Expected outcomes include:

1. developing an in-depth understanding of the key elements necessary for complication rescue,
2. designing an intervention that promotes key elements for improving the rescue process, and
3. pilot-testing and evaluating the intervention.

The results have the potential to inform interventions to reduce mortality in surgical patients.

For more information about the project, please visit: https://www.improvingsurgery.com/mrescue.

MICHIGAN LAW UPDATES ON CONGENITAL SYPHILIS AND PERINATAL HIV TESTING

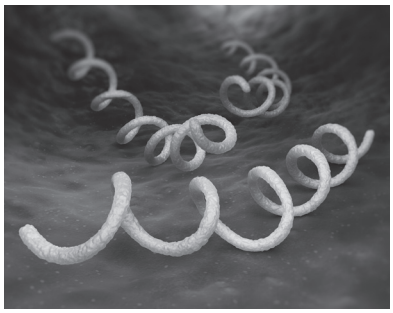
Michigan has seen an increase in cases of congenital syphilis (CS) and perinatal HIV in recent years. Both CS and perinatal HIV infections are 100% preventable and result from inadequate prenatal testing and treatment. Any case of CS or perinatal HIV is considered preventable and a failure of public health. Health care providers should be cognizant of this increase and take the necessary steps to ensure proper testing and treatment of pregnant patients. In Michigan, many cases of CS are attributable to pregnant women not receiving comprehensive treatment according to CDC guidelines

prior to delivery.

In December 2018, the Michigan Legislature updated its Perinatal HIV/STD testing laws. These changes have aligned Michigan's testing laws with the Centers for Disease Control and Prevention guidelines for HIV and STD testing during pregnancy and at delivery.

The updated law (Michigan's House Bill 6022) states:

- All pregnant women shall be tested for HIV, hepatitis B virus (HBV), and syphilis at their first prenatal visit (unless the patient refuses).
- All pregnant women are to be retested for these infections during the third trimester. The Michigan Department of Health and Human Services recommends this to occur at 28 weeks, or as soon thereafter as possible, to allow for timely treatment or referral to services.
- Pregnant women who present for delivery without documentation of previous testing or declination and reason for refusal are to receive stat testing. Patients can consent to an HIV test verbally or in writing, a separate consent for HIV testing is no longer required. A patient who provides general informed consent for medical care is considered to have consented to an HIV test. If an HIV test is declined, providers are required to document refusal of testing in the patient's medical record.



Health care providers have a critical role to play in ensuring the health and well-being of women and babies in Michigan. Michigan's recent law change aims to identify infections early, treat infections according to published guidelines, and work with public health to ensure that sexual partners are also tested and treated. If you have any questions about congenital syphilis or perinatal HIV, please contact Aleigha Phillips, MDHHS Congenital Syphilis/Perinatal HIV Coordinator, at 313-456-1330.

For additional resources:

- Midwest AIDS Training and Education Center - Michigan: 313-962-2000; Mary Rose Forsyth: 313-408-3483
- National Perinatal HIV Consultation and Referral Service: 1-888-448-8765
- Michigan.gov/HIVSTD

MICHIGAN PHYSICIANS MEET WITH MEMBERS OF CONGRESS, ADVOCATE FOR PATIENTS

In February, a delegation from the Michigan State Medical Society traveled to Washington, D.C. for the American Medical Association's National Advocacy Conference (NAC). The NAC is an annual event that brings together physician advocates from across the country to meet with their respective members of congress on a range of issues impacting the medical profession and patient care. The issues that were front and center of this year's agenda included reforming prior authorization, reining in prescription drug costs, out-of-network medical billing, adequate funding for mental health services, as well as the Conrad 30 program, and the related green card backlog.

This year's Michigan delegation included MSMS President-Elect and AMA Board of Trustee Member, Bobby Mukkamala, MD; MSMS Legislation and Regulations Committee Chairman Brad Uren, MD; MSMS Board Member Nita Kulkarni, MD; Wayne County Medical Society President Salim Siddqui, MD; MSMS Board Member Amit Ghose, MD; Steven Daveluy, MD; Vahid Pasovic, MD; MSMS student member Miriam Rienstra Bareman; MSMS Chief Executive Officer Julie Novak, MSMS Senior Director of Physician Engagement and Organizational Integration Joshua Richmond and Director of State and Federal Government Relations Sarah Waun.

The group met with several members of the Michigan congressional delegation to discuss the topics at hand and how they were impacting their practice and patients back in Michigan. Much of the discussion focused on how the divided congress and the administration can find common ground, acknowledging that there is some consensus around the issues of out-of-network medical bills and the reauthorization and expansion of the Conrad 30 program.

JOSEPH D. KROON, MD

August 18, 1930 - February 10, 2019

Dr. Joseph Dennis Kroon, MD, age 88, passed away peacefully at his home surrounded by his family on Sunday, February 10, 2019.

He was born August 18, 1930 in Mount Clemens to John and Lavinia Hagen Kroon.

Joseph graduated from St. Mary Catholic School in Mount Clemens. He attended pre-med at University of Notre Dame and graduated with a degree in medicine from the University of Michigan. In 1962, he began practicing Obstetrics and Gynecology in Macomb County and retired in 2000 after 40 years of practice. In the course of his career, he served as Chief of Staff of Obstetrics and Gynecology at Saint Joseph Hospital in Mount Clemens and was a long-time member of the Macomb County Medical Society. He was also a member of the Mount Clemens Old Crowd, for many years. An avid golfer and boater, you could often see him pedaling around his neighborhood on his bicycle.

Joseph will be lovingly remembered by his wife of 64 years, Shirley (Dunlap) and his children, Laurie Kroon, Joseph (Laura) Kroon, Mary (Timothy) Duffy, Ned (Shari) Kroon, and Jill (John) Jacobson. Joe will be fondly remembered by his eleven grandchildren, Joseph, Nouwaf, Danielle, Jeffrey, Erin, John, Gia, Katelyn, Maeghan, Cassandra and Samantha and 15 great grandchildren. Besides his parents, he was preceded in death by brothers, John, James, Francis, and Gerald.

Burial was at St. Peter Catholic Cemetery, Clinton Township, Michigan.

Contributions may be addressed to St. Mary School Hearts and Stones Endowment Fund.

Henry Ford Macomb Hospital

CALENDAR CELEBRATES TRIUMPH OVER ADDICTION

Henry Ford Macomb Hospitals has partnered with CARE of Southeastern Michigan and Project Vox, a recovery advocacy group, to produce the 2020 Faces of Recovery calendar, which highlights the success of people in long term recovery from drug and alcohol addiction.

The annual calendar, which debuted in 2007, spotlights residents from around the region, each offering personal messages of hope and encouragement, drawing on their own experiences.

Eric Koselansky of Macomb Township has been clean and sober for 3 years. "I'm excited to be included in this year's calendar to encourage others battling addiction and show them that recovery is possible," said Eric.

Approximately 5,500 copies of the 2020 calendar will be distributed throughout the metro Detroit area by CARE and various advocacy groups. Henry Ford Health System also makes the calendars available to behavioral health patients.

To request a free copy of the calendar, phone CARE at (586) 541-2273.

Note: Select people featured in the calendar are available for phone interviews. Contact Michelle Fusco at (586) 263-2891 to coordinate.

About the partners

Henry Ford Health System
Henry Ford Health System offers comprehensive addiction treatment throughout southeast Michigan, including:

- Residential addiction treatment for adults
- Comprehensive outpatient programs, including medication-assisted treatment
- Community education and family support groups

For information about addiction treatment at Henry Ford, visit www.henryford.com/addiction or call (800) 422-1183.

CARE of Southeastern Michigan
Founded in 1977, CARE of Southeastern Michigan's mission to strengthen resiliency in people and their communities through prevention, education, and services that improve the quality of life. Each year CARE of Southeastern Michigan impacts the lives of 25,000 people through more than 45 different programs and services. CARE of Southeastern Michigan serves individuals across the lifespan, from early childhood programming through older adult services. Call (586) 541-2273 or visit www.careofsem.com.

Greater Macomb Project Vox
The mission of Greater Macomb Project Vox is to unify the voice of the recovery community in order to reshape public attitudes and eliminate the discrimination toward individuals who are living with an addiction to alcohol and other drugs. For more information, visit www.projectvox.com.

NEW ORTHO WALK IN CLINIC OPENED IN CHESTERFIELD

A new orthopedic walk-in clinic is now open at the Henry Ford Macomb Chesterfield Health Center, 30795 23 Mile Road, Ste. 209. The new clinic sees patients with injuries to wrist, hand or shoulder, possible broken bones, sprained knees, sports injuries or swollen joint, ankle or foot. Services not available include cortisone injections, treatment for chronic conditions, including pain management, second opinions for orthopedic issues or worker's compensation injuries.

Appointment or physician referral is not needed unless required by insurance, and patients are charged only for an office visit. The clinic is currently open Mondays from 4 to 8 p.m., with expanded hours expected soon.

HENRY FORD MACOMB IS TOP HOSPITAL FOR PATIENT SAFETY, QUALITY

For the second year in a row, Henry Ford Macomb Hospital was named a Top Hospital for patient safety and quality by The Leapfrog Group.

Henry Ford Macomb is the only hospital in Macomb County and among 120 to earn the distinction from about 2,100 hospitals nationally. The Top Hospital designation is determined by a methodology that measures hospital care performance across multiple areas including infection rates, maternity care, mortality and physician staffing in the intensive care unit.

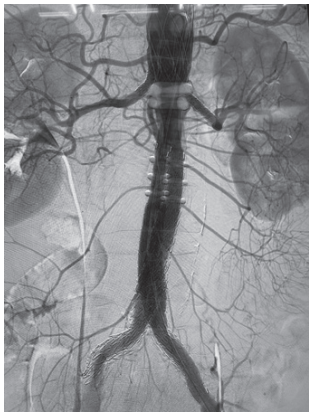
"This honor reflects the collective efforts of everyone who works at Henry Ford Macomb," says Barbara Rossmann, the hospital's president and CEO. "Each day we strive to deliver the highest standards of care to our patients in a safe, healing environment. I'm extremely proud of our team members and our medical staff for making this honor possible."

Top Hospital designations are awarded in four categories: children's hospitals, general hospitals, rural hospitals and teaching hospitals. Henry Ford Macomb was honored in the top teaching hospitals category, reflecting their robust medical education curriculum offered to physicians, nurses, residents, fellows, interns, students and allied health professionals.

The Top Hospital honor comes one month after Henry Ford Macomb earned an A grade for patient safety performance in The Leapfrog Group's bi-annual safety grades.

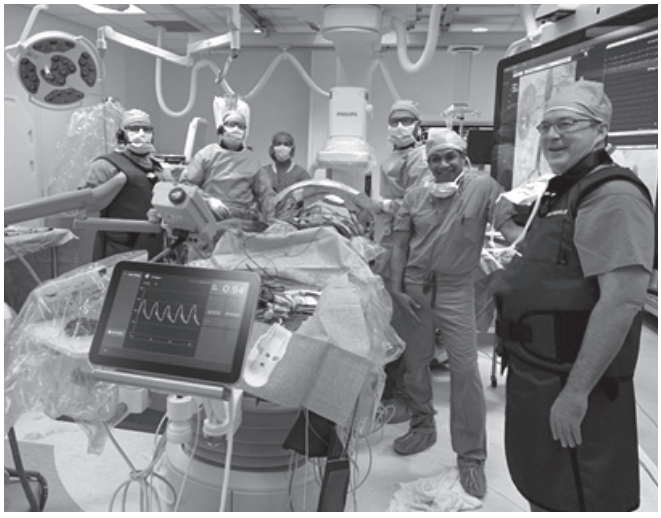
Ascension Macomb-Oakland Hospital

ASCENSION MACOMB-OAKLAND HOSPITAL PERFORMS EVAR IN CATH LAB



It was a first for Ascension Macomb-Oakland Hospital when interventional cardiologists recently performed an Endovascular Aneurysm Repair (EVAR) in the hospital's Cath Lab. The procedure was performed through the initiative of Theodore Schreiber, MD, Chief of Cardiovascular Services, Ascension Macomb-Oakland; and the operating physicians James Martin, MD, Chief of Cardiovascular Surgery, Ascension Macomb-Oakland Hospital; and Thomas Davis, MD, Interventional Cardiologist.

Physician proctor Dr. Venkatesh Ramaiah, Chief Vascular Surgeon from Honor Health of Scottsdale, Ariz., assisted with the procedure. Wael Dabaja, MD, Interventional Cardiology Fellow, was first assist. The patient had a very complicated 7mm aortic abdominal aneurysm. The EVAR was performed using an ovation abdominal stent graft with bilateral renal and iliac stenting (shown on the angiogram/photo).



Pictured L-R: Chris Madden, RN; Chris Ottinger, RN, Lead Preceptor; Henry Uban, CRNA; Dr. Wael Dabaja, Interventional Fellow; Dr. Ramaiah, EVAR physician proctor, and Dr. Thomas Davis, Interventional Cardiologist.

Pictured L-R: Dr. James Martin and Dr. Thomas Davis.

ASCENSION ST. JOHN HOSPITAL OPENS SPECIALIZED STROKE UNIT

In mid-January, Ascension St. John Hospital opened its much-anticipated Stroke Unit, a first for Ascension Michigan and the health system nationally.

The new Stroke Unit features 22-private rooms and is considered a best in practice model for treating stroke patients. The unit is unique in that it will employ the latest treatment and rehabilitation methods through a multi-disciplinary team, which includes dedicated:

- Rehabilitation therapists
- Care management team
- Advanced Practice Nurses certified in stroke care
- Pharmacist

"Our new specialized stroke unit will help us meet increasing patient demand and incorporate the most current model of care, which calls for increasingly specialized services that decrease the length of hospital stay and improve patient outcomes," said Paul Cullis, MD, Medical Director, Stroke program.

Historically, stroke patients were treated on the Intensive Care Unit (ICU) and oftentimes this could overburden the ICU. By creating a dedicated stroke unit, Ascension St. John will also be able to alleviate stress on the ICU.

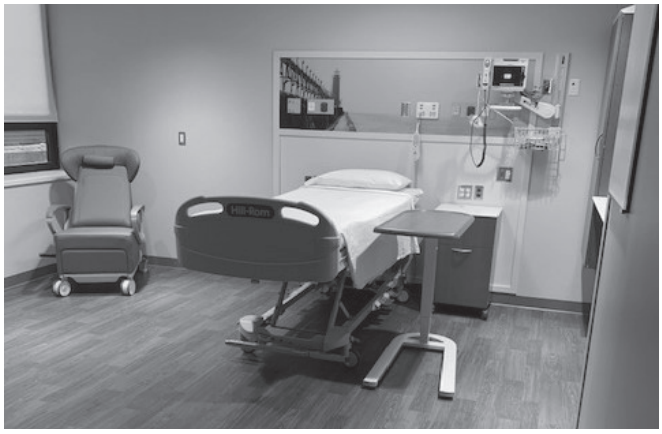
Ascension St. John Hospital is one of three Comprehensive Stroke Centers within Ascension Michigan and the only one on the eastside of metro Detroit. It serves 700 acute stroke patients a year. Ascension Michigan treats more strokes than any other health

system in the state. Nationally, Ascension has 11 Comprehensive Stroke Centers.

Ascension St. John Hospital leaders held a ribbon cutting and dedication on January 22 for the new Stroke Unit which is located on 1 East.

Pictured L-R: Makenzie Thimm, NP, Stroke Coordinator, and Dr. Paul Cullis, Medical Director, Stroke program.

Pictured below is one of the private patient rooms.



While the stroke unit was funded through a capital improvement project, the Fontbonne Auxiliary also contributed $100,000 from the 2018 White Christmas Ball. The patient family lounge will be named for the Fontbonne.

ASCENSION MACOMB-OAKLAND RESIDENT SAVES CARDIAC PATIENT AT PLANET FITNESS GYM

Dr. Leslie Terrell, an Internal Medicine Resident at Ascension Macomb-Oakland Hospital, was at the right place at the right time. Dr. Terrell was working out at the Sterling Heights Planet Fitness last month when she came to the aid of a 52-year-old man who "fell off" a treadmill while exercising. With quick action, Dr. Terrell, Planet Fitness staff and a bystander noticed the commotion and rushed to the man's aid. Dr. Terrell determined the man was in cardiac arrest. The staff called 911 and retrieved the AED. At the direction of Dr. Terrell, CPR was started and the AED was applied (two shocks) with success. Upon arrival of the Sterling Heights Fire Department, the patient had a pulse and was breathing. EMS assessment found the patient pale, diaphoretic, and confused. Enroute to the hospital, a 12-lead EKG was performed showing PVCs and ST elevation in V-1, V-2, and AVR with reciprocal changes in the expected leads. The cath lab was notified and the patient received prompt treatment upon arrival. The patient was discharged a few days later in stable condition. Thank you, Dr. Terrell, for jumping into action and saving this man's life.

Ascension Macomb-Oakland Hospital leadership honored those involved with saving the patient's life.

Pictured L-R: EMS Chief Kelly Burgen, Sterling Heights Fire Department; Planet Fitness General Manager; Dr. Leslie Terrell, Ascension Macomb-Oakland Hospital Internal Medicine Resident; and Dr. Michael Feld, Deputy Medical Director, Ascension Macomb-Oakland Hospital, and Medical Director, Macomb County Medical Control Authority.

McLaren Macomb Hospital

MICHAEL J. D'ALMEIDA, DO, NAMED CHIEF OF STAFF AT MCLAREN MACOMB

Michael J. D'Almeida, DO, a general and bariatric surgeon at McLaren Macomb, has been named president and chief of the hospital's medical staff. Dr. D'Almeida most recently served as the medical staff's vice president and assumes the role vacated by Dr. Beth Wendt, whose term ended at the close of 2019.

In this role, Dr. D'Almeida looks forward to leading the McLaren Macomb medical staff as the hospital continues to grow its services and add to its facilities.

"It's an exciting time for McLaren Macomb, with initiatives underway that directly benefit the community and the hospital's ability to enhance its level of care," Dr. D'Almeida said. "This enthusiasm extends to the medical staff, and I look forward to working with our incredible staff to move ahead cohesively while remaining committed to this vision."

A board certified general surgeon, Dr. D'Almeida specializes in the utilization of advanced surgical technology, which includes laparoscopic and endoscopic procedures, while also possessing extensive experience in traumatic and oncologic surgeries, and nutrition and metabolic medicine.

Prior to serving as an officer of the McLaren Macomb medical staff, Dr. D'Almeida's administrative experience included serving as chief of surgery at McLaren Macomb and director of the Great Lakes Bariatric Treatment Center while it was affiliated with the hospital. He also serves as the director of the Nutrition and Metabolic Support Team.

Dr. D'Almeida has spent his entire professional career at McLaren Macomb, beginning when he chose then - Mount Clemens General Hospital for his general surgery residency after his graduation from the University of Health Sciences College of Osteopathic Medicine in Kansas City.

While on the McLaren Macomb medical staff for more than 25 years, Dr. D'Almeida also spent four years as an active duty US Naval Surgeon.

MCLAREN MACOMB EARNS BCBS BLUE DISTINCTION CENTER FOR SPINE SURGERY DESIGNATION

McLaren Macomb has earned recognition for its orthopedic spine surgery proficiency by Blue Cross Blue Shield of Michigan, who named the hospital a Blue Distinction Center for Spine Surgery. Blue Distinction Centers for Specialty Care is a directory created to identify facilities with proven expertise in delivering specialty care.

Blue Distinction Centers are "healthcare facilities and providers recognized for their expertise in delivering specialty care," as stated on the BCBS website. Specific to spine surgery, these centers offer discectomy, fusion and decompression procedures, and have low readmission rates and fewer reoperations.

The Distinction Center Program was developed with input from the medical community and evaluates hospitals' specialty care and their ability to deliver high-quality outcomes.

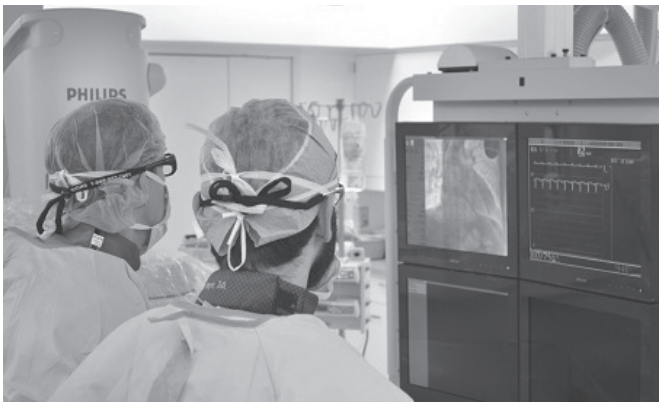
"Back pain can be one of the most frustrating and debilitating chronic conditions anyone can experience," said Dr. Anthony Cucchi, orthopedic spine surgeon with McLaren Macomb. "When it comes to the importance and delicate nature of the spine, trust between the patient and the surgeon and care team is essential. A designation from a reputable organization helps to impress upon our patients the level of care they can expect from our facility."

BCBS also takes into account the expertise of the medical team, the number of times the facility has performed a procedure and the facility's track record for results, resulting in fewer complications and readmissions than facilities without the designation.

Part of a comprehensive orthopedic and joint replacement program, spine surgeons at McLaren Macomb utilize minimally invasive procedures to relieve patients of chronic, debilitating back pain, resulting in a quicker recovery and less of a need for post-op pain medications.

MCLAREN MACOMB REPORTS ENHANCED TAVR PATIENT OUTCOMES, EXPANDS PROGRAM

McLaren Macomb, through its Mat Gaberty Heart Center, has reported exceptional clinical outcomes for patients who have undergone a transcatheter aortic valve replacement (TAVR), a minimally invasive procedure originally introduced to replace the heart's aortic valve in patients deemed a high- or intermediate-risk for heart surgery.



Performed in the cardiac catheterization lab, patients living with severe aortic stenosis receive a TAVR to replace the malfunctioning aortic valve with an organic valve supported by a metallic stent.

McLaren Macomb cardiologists launched the TAVR program in the spring of 2018, and in the months since, quality of life indicator data supports enhanced clinical outcomes for those patients who have undergone the procedure to replace the critical heart valve.

Patients who received TAVR reported an average quality of life increase of 56.25 when returning the Kansas City Cardiomyopathy Questionnaire (KCCQ). The industry standard, the KCCQ is a measurement in which patients self-report the impact their heart disease symptoms are having on their quality of life, generating a score on a scale of 0 to 100.

Continued on pg. 17

Thank You Letters

January 27, 2020

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 $2,100 to the Macomb Food program.

The Macomb Food Program serves people in need of food throughout the County of Macomb through its network of over 60 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. Thank you for your generous support of our program!

Gratefully,

Michael Sheridan
Chairperson

Shannon Mallory
Food Program Manager

January 29, 2020

Dear MCMS Foundation,

During the holiday season, we are reminded of the power of hope. Hope for our survivors and their journey of healing. Thanks to your gift of $2,155, from the Holiday Sharing Card Project, survivors of domestic and sexual violence will have access to **free, life-changing programs, including our Shelter and 24-hour Hotline, Personal Protection Orders (PPO) and Legal Advocacy, Counseling, and our Forensic Nurse Examiner Program.**

2020 marks Turning Point's 40th year of providing emergency and supportive services. Since our inception, we have served over 100,000 domestic violence and sexual assault survivors.

We thank you for helping survivors regain control of their lives and for giving them the gift of hope.
Thank you so very much!

Happy Holidays,

Sharman Davenport, PhD
President/CEO, Turning Point

We would like to welcome several new members from the Greater Macomb Physician Network and Henry Ford Health System

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MEMBER NEWS

Call for Officer Nominations

The MCMS Board of Directors is looking for members interested in participating as an officer or delegate.

The MCMS Board meets four to six times per year, usually for a dinner meeting on Tuesday evenings. Delegates are also expected to attend the annual Michigan State Medical Society House of Delegates which will be held April 25 - 26, 2020 at The Henry Autograph Collection in Dearborn.

Anyone interested in running for a position on the MCMS Board please contact Heidi Leach at macombcms@gmail.com.

Cultural Diversity Creates Language Barriers: Reducing Claims with Multilingual Patients

Rich Cahill, JD, Vice President and Associate General Counsel, and Susan Shepard, MSN, RN, Senior Director, Patient Safety Education, The Doctors Company

MS. D., A NATURALIZED U.S. CITIZEN FROM SOUTHEAST ASIA, PRESENTED TO DR. P. FOR A CONSULTATION REGARDING EXTENSIVE ACNE SCARRING ON HER FACE AND NECK. THE PATIENT REPORTED THAT SHE FELT SELF-CONSCIOUS ABOUT HER APPEARANCE AND SOUGHT ADVICE ON POSSIBLE TREATMENT OPTIONS. ACCORDING TO THE CHART, MS. D. SPOKE LIMITED ENGLISH. HER READING PROFICIENCY WAS NOT NOTED.

Following an examination of the affected area, Dr. P. offered CO2 laser resurfacing. The benefits and potential disadvantages of the procedure were discussed, including the possibility that her complexion type posed an increased risk of scarring and changes in pigmentation. Ms. D. subsequently agreed to undergo laser resurfacing and signed a written consent that specifically identified scarring and changes in skin color as possible postoperative outcomes.

The patient returned the following week. The treatment record reflects that Dr. P. performed the procedure under local anesthesia and conscious sedation. The surgery was uneventful, and no intraoperative complications occurred.

Ms. D. presented on numerous occasions over the next several months. Hyperpigmentation was noted, and Solaquin Forte 4% and Pramosone lotion were prescribed. At one point, the patient complained of experiencing a burning sensation on her face. Approximately one year after the procedure, Ms. D. returned for further evaluation. The scarring was barely visible; the discoloration on her neck was noticeably improved. However, the patient expressed dissatisfaction with the result.

Ms. D. thereafter retained counsel and initiated suit alleging causes of action for medical malpractice and negligent infliction of emotional distress. In substance, the patient claimed that because of her limited proficiency with English and the failure by the physician to utilize any translation services, including for any preoperative documentation, there was no informed consent.

Providing Language Services: Obligations and Benefits

Clear and unambiguous communication constitutes the key component of the physician-patient relationship. Misunderstandings often create frustration and distrust, especially when an adverse event occurs, and can result in professional liability litigation or reports to state medical boards and third-party payers by disgruntled patients and family members. Proactively implementing office procedures for both physicians and staff to promote optimum communication reduces the risk of surprise and the potential for expensive, protracted, and unpleasant disputes.

With our culturally diverse national population, including many who speak a language other than English at home, language barriers raise the risk for an adverse event. The Department of Health and Human Services (HHS) Revised Guidance Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons outlines the requirements for recipients of federal financial assistance from HHS to take reasonable steps to ensure LEP persons have access to language services. (These recipients do not include providers who only receive Medicare Part B payments. However, providers that receive funding from any government program such as Medicaid or Medicare Advantage are subject to the requirements.)

To determine the extent of the obligation to provide language assistance, analyze the following four factors:

- **Number:** The greater the number or proportion of LEP persons served or encountered by your clinic, the more likely language services will be needed.
- **Frequency:** Even if unpredictable or infrequent, there must be a plan for providing language assistance for LEP persons.
- **Nature:** Determine whether a delay in accessing your services could have serious or life-threatening implications. The more important the nature of the services you offer, or the greater the consequences of not accessing treatment, the more likely language services will be needed.
- **Resources:** Consider the resources available and the cost to provide them. As a solo practitioner, you are not expected to provide the same level of service as a large, multispecialty group. Investigate technological services or sharing resources with other providers.

It is not recommended to use a family member as an interpreter. Lay personnel are rarely familiar with medical terminology. Additionally, the patient may not want a family member to access their confidential health information.

An adult family member should serve as interpreter if a family member must be used - unless no adult is available, and care must be provided immediately to prevent harm. It is preferable to have a trained clinical staff member provide interpretation; alternately, your practice can use certified interpreter services. Consult your local hospital or the patient's health plan for a list of qualified

interpreters. Other resources include a local nationality society, the Registry of Interpreters for the Deaf, or the local center for the deaf. Also, keep consent forms - especially for invasive procedures - translated into the applicable non-English languages by a certified translator.

The Agency for Healthcare Research and Quality (AHRQ) has prepared a guide, Improving Patient Safety Systems for Patients With Limited English Proficiency, which recommends that practices focus on the following:

- Medication use: Understanding medication instructions is complicated for all patients, but even more difficult for LEP patients. Both patients and providers need to communicate accurately about mode of administration, allergies, and side effects.
- Informed consent: Obtaining informed consent remains a hallmark of patient safety and a critical medical and legal responsibility. Achieving truly informed consent for LEP patients may require extra effort, but LEP patients should not be excluded from learning about choices that might affect their health and well-being.
- Follow-up instructions: Understanding discharge instructions is especially challenging for LEP patients. Speaking Together: National Language Services Network, a project funded by the Robert Wood Johnson Foundation, which created the Speaking Together Toolkit, found the need for greater use of interpreters at key moments of information exchange, such as at assessment and discharge - not just during the acute phase of treatment.

Relatively simple communication tools can provide some helpful solutions. These include:

- AskMe3™: Rx for Patient Safety: Ask Me 3
- The teach-back method: AHRQ: Use the Teach-Back Method: Tool #5
- The SHARE approach: AHRQ: The SHARE Approach - Using the Teach-Back Technique: A Reference Guide for Health Care Providers
- Patient experience surveys: The Doctors Company: Patient Experience Surveys

To protect your patients from harm resulting from their LEP, develop and implement a plan for language access in your practice. For more information, see the Centers for Medicare and Medicaid Services' Guide to Developing a Language Access Plan.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

HOSPITAL NEWS *continued from pg. 11*

Following treatment, patients complete the same questionnaire (at 30 days and again at one year from the date of treatment) in order to measure the overall effectiveness of the treatment.

"What our data demonstrates is that the program is working as it's intended to," said Dr. Timothy Logan, interventional cardiologist and chief of cardiology at McLaren Macomb. "Patients who were suffering the symptoms of aortic stenosis are returning home feeling much better with a greater quality of life."

The announcement of these quality statistics coincide with the McLaren Macomb TAVR team's expansion of the program to include additional patient populations.

Dr. Logan and the team are now capable of performing an alternative access approach to the procedure - accessing the malfunctioning heart valve via the carotid artery in the neck to accommodate patients who, for any reason, might not be able to tolerate access from the femoral artery in the groin.

Additionally, the team has broadened the TAVR inclusion criteria to include the procedure as a primary treatment option for patients who are at low-risk for heart surgery, a move approved by the US Food and Drug Administration (FDA) following clinical trials.

"While TAVR was originally introduced as an option for patients deemed too high-risk for surgery, we now have clinical data to support that this treatment is effective in low-risk patients as well," Dr. Logan said. "As a result, we are excited to offer TAVR as the primary treatment option for more patients at McLaren Macomb."

A very common condition, aortic stenosis is a narrowing of the aortic valve, keeping it from fully opening, reducing the amount of blood pumped through the heart. Forced to work harder, the heart is weakened, causing symptoms of chest pain, fatigue and shortness of breath, among others.

Baby Resource Network of Macomb Resource Guide

From: Macomb County Health Department

NATIONALLY, MATERNAL AND INFANT MORTALITY ARE MAJOR PUBLIC HEALTH CONCERNS. ACCORDING TO DATA COLLECTED BY THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE 2017 INFANT MORTALITY RATE DEPICTED THAT FOR EVERY 1,000 MICHIGAN LIVE BIRTHS, 6.8 INFANTS DIED BEFORE REACHING THEIR FIRST BIRTHDAY. IN MACOMB COUNTY, THERE WERE 7.3 INFANT DEATHS PER 1,000 LIVE BIRTHS IN 2017.

The Baby Resource Network of Macomb is a coalition working together to improve maternal and infant health in Macomb County, and thereby, impact the rate of infant deaths. This coalition is chaired by Macomb County Health Department and is comprised of representatives from a variety of agencies. The coalition has established a Mother Baby Health Improvement Plan to be implemented across a span of five years, 2018-2022. This plan consists of five goals, one of which is to communicate the availability of resources to health care providers in Macomb County. A resource guide has been created in both print copy and electronically to communicate these resources to health care providers in Macomb County. The guide features resources intended to benefit pregnant women and families with infants and young children. Resources detailed in the guide are relevant to the needs of the targeted population and include resources for health care, dentistry, transportation, mental health, nutrition, and more.

Members of the Baby Resource Network of Macomb are looking to disseminate the print copy of the guide to practices that specialize in obstetrics and gynecology, pediatrics, family medicine, internal medicine, and other areas that serve moms and babies. Physician offices can find great benefits in utilizing this resource guide to connect their clients to a wide array of services. Along with this guide, healthcare offices will receive safe sleep information and rack cards, along with a healthy baby & pregnancy poster for display.

If your office would like to order a resource guide, or any of the accompaniments, please visit the Macomb County Health Department website and complete an order form at: https://health.macombgov.org/Health-babyresourcenetwork

For faster access to the website and electronic access to this guide, scan the QR code below. If you have any questions, please contact Macomb County Health Department at 586-469-5520 or via email at babyresourcenetwork@macombgov.org.

Thank you,

Baby Resource Network of Macomb

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 macombcms@gmail.com with newsworthy information.

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

PROVIDING LETTERS OF RECOMMENDATION FOR DEPARTING STAFF:

A Worthwhile Pursuit or an Invitation for a Lawsuit?

By: Jodi Schafer, SPHR, SHRM-SCP, owner of Human Resource Management Services, LLC

Q:

One of my top performing staff members gave notice. She has been an outstanding employee and is leaving because her husband has been transferred out-of-state. She asked me for a letter of reference, which I happily provided. In this letter I sang her praises describing her strong customer service skills, her attention to detail and her loyalty to the practice. She was pleased with it and shared it to another staff member.

Shortly after this occurred, one of my mediocre employees resigned. She also asked for a letter of reference. Unfortunately, I had very few positives to say about her. So, I wrote a letter that was generic. It included a statement that, "She did what was asked of her," and verified her hire date and wage. She was upset with letter and wanted to know why her letter was not as nice as her co-worker's. When I told her that I had some problems with her performance and that I was not going change her letter, she became very upset saying that I should have told her about these problems.

Is this going to get me in trouble? Should I try to fix this and if so, how?

Answer: To answer your first question, no. I don't believe your letter will get you in any trouble because you did not write any negative, unsupported comments about the mediocre employee. Her issue was not with what you said, but rather what you didn't say.

In Michigan, an employer is presumed to be acting in good faith and thus immune from defamation lawsuits while providing a reference if you can answer in the affirmative to the following questions:

1. Are the comments job-related? For example, you can say an employee "was always on time," but you should not continue that sentence with - "even though she had three children at home." Her motherhood is not job-related.

2. Are the comments you made true? Opinion is different than facts. Attendance records or patients' comment cards with complaints are facts. Without documentation in the personnel file to back up your comments, you should avoid talking about it.

3. Is the behavior/performance documented in the employee's file? This is where you could have avoided a bit of heartache with your most recently departing employee. If you had addressed the problems in her performance appraisal, with her signature, she wouldn't have been surprised by your generic letter. Any negative comments you might make while providing a reference should be supported by documentation in the employee's file.

4. Are you allowed to share this information in accordance with state and federal law? We hit on this a bit in question #1. Be sure you aren't sharing confidential employee information that is prohibited by law, I.e. anything to do with an employee's protected classification and/or health history.

Based on this information and the content of the second employee's letter, you have nothing to fix in this current scenario. If you wanted to put a more consistent process in place for the future, you might consider limiting what you say in your letters to the employee's name, position, dates of employment and whether or not s/he was an employee in good standing when they left. You can then close the letter with permission to contact you for more information. When a prospective employer calls to follow-up, you can then elaborate on how great (or not great) the ex-employee was using the questions listed earlier to guide your conversation.

To add another layer of protection, I encourage you to get a signed release from the ex-employee before providing any additional information (verbal or written) regarding performance, behavior and/or attendance. You can build the same thing into your hiring process by adding this clause to your employment application. That way you have a signed document to share with past employers whom you are calling for a reference.

While providing references can be a touchy area, they are a valuable part of the hiring process. Because of this, I encourage you to keep providing them (either verbally or in writing), using the information provided here as your guide. Many times, the same employee is jumping from one office to another in a community. You want to establish a relationship with these offices so they can feel comfortable telling you the truth about an employee, good or bad, and you can do the same in return.

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 877-264-6592 or email macombcms@gmail.com 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!*

HEALTH CARE 2020: HERE'S WHERE CONGRESS AND THE STATES ARE HEADED

By: Andis Robeznieks, Senior AMA News Writer

A divided Congress and a presidential election year create impediments to passing meaningful health care legislation. But Todd Askew, the AMA's new senior president of advocacy, believes there are still opportunities for bipartisan bills to pass.

Helping in this regard is a May 22 deadline to extend funding for popular health care programs and the fact that, according to a Gallup poll, health care concerns such as cost, access and coverage were the top issues on voters' minds in the 2018 midterm elections, and politicians want to be viewed as being on the right side of those topics.

During the recent AMA State Advocacy Summit in Bonita Springs, Florida, Askew noted that Washington gridlock opens the door for serious state-level health reforms.

Askew, the former AMA director of congressional affairs, also offered tips for physician advocates lobbying their legislators and he reflected on the legacy of his predecessor, Rich Deem, who spent 35 years at the AMA advocating for doctors and patients.

What should physicians anticipate on surprise billing legislation?

Askew: Election years are always a difficult time to move significant pieces of legislation. The issue of surprise billing, however, has received a lot of news media attention and has a particularly populist appeal and broad support among patients and employers that's generated bipartisan interest given the importance of health care costs as a significant issue in the election.

So, I think certainly there will be a continued effort to advance surprise billing legislation, especially prior to a late May deadline for the enactment of other health care extenders. I think that we are making progress in moderating the legislation - making it more fair for physicians while still protecting patients. And so that would be the goal I have, that it's able to go before May 22.

What is the significance of the May 22 deadline?

Askew: There are several health care extenders that were passed as part of the fiscal year 2020 spending package, but they only run until May 22, and that is actually the hard stop before a congressional recess. So, it's kind of a forcing action for them to get something done. You'll also probably see an effort to include some sort of drug-spending legislation in that package sometime during the month of May.

The "extenders" include health programs that are constantly having to be reauthorized. They include things like the National Health Service Corps Scholarship Program, community health centers and the Teaching Health Center Graduate Medical Education program. These are good, popular programs that don't have a lot of controversy around them, but that Congress never seems to get around to passing longer-term authorizations. But they can also be a tool for Congress to drive other health care policies knowing that they must eventually pass legislation to extend these.

What major issues are being stalled by congressional gridlock?

Askew: The biggest two right now are, obviously, surprise billing, which we continue to work on, and drug-price legislation, which has really run into barriers - both in the House and the Senate. The House passed its bill on a partisan vote. But that legislation doesn't stand much of a chance of being considered in the Senate.

On the Senate side, there is bipartisan legislation that Sen. Charles Grassley, [R-Iowa], and Sen. Ron Wyden, [D-Ore.], have introduced and reported out of committee. But it finds a lot more support among Democrats than Republicans, so Senate Majority Leader Mitch McConnell, [R-Ky.], is highly unlikely to put that bill onto the Senate floor with significant Republican opposition. I think that, if they find some sort of compromise to bring some more Senate Republicans on board, that there's a chance you could see legislation passed later this year. But there's a long way to go before that happens.

At the state level, what's the status of prior-authorization reform?

Askew: Obviously, states can only regulate insurance products that are sold in the individual market or the fully insured market as opposed to those that are covered by the [Employee Retirement Income Security Act of 1974] ERISA, which can only be regulated by the feds.

There have been some states that have made significant improvements. One important example is Pennsylvania's and other states' prohibition of Medicaid prior authorization for medication-assisted treatment for opioid-use disorder. We've seen a growing amount of success across the country with states moving to prevent payers from requiring those extra steps for people who are trying to get into recovery.

How can doctors effectively communicate with policymakers on scope of practice?

Askew: In dealing with scope of practice, it's important to be factual, to talk about the differences in education and training between different types of health care professionals. It's important to present data about the differences in outcomes or treatments provided by the different types of professionals. It's important not to be dismissive of their skills for what they are trained and licensed to do. And it's always important to emphasize the value of non-physician providers as critical parts of the physician-led health care team.

I think folks will also hear that "physicians are just trying to protect their turf." But I think that the data demonstrates real differences in the care provided. And, certainly, the differences in the education and training should be self-evident. Also, frequently you'll hear that "doctors don't go to the rural or underserved areas where non-physician providers go." But the AMA Health Workforce Mapper points out pretty clearly that all health professionals tend to practice in the same areas and there's not a glut of underutilized non-physician providers in rural areas.

How do you channel younger physicians and medical students' passion on issues such as climate change and gun violence into legislative or regulatory action?

Askew: I think the more passionate you are about an issue, the better advocate you can be. All of these are issues that the AMA is engaged in, one way or another. It's important to be realistic about what can be accomplished in the short term, but certainly the evidence is clear on the potential health impact of climate change, the impact of gun violence in the United States and the role of social determinants of health in the health challenges that so many people face. I would just encourage them to bring the evidence forward and advocate on those things.

If these issues bring medical students and physicians into the fold, how do you sustain their interest?

Askew: Once people get a taste for advocacy, a lot of people tend to fall in love with it. It's important that, just like anything else you do, you practice, repeat and stay engaged. Not necessarily calling every day, but trying to stay in regular contact with your legislators and their staffs about those issues. Staying abreast of the news and following up after your meetings are all important to remaining engaged in the long term.

How should physicians engage with legislators when they don't always see eye to eye?

Askew: It's unlikely you're going to find anybody that you agree with on 100% of the issues. If you need to work with someone on one issue, it's not worth dwelling on issues where you may disagree. It's important to find common ground and to see where you could work together on those areas where you agree or where your positions are close enough that you might find some common understanding.

If there's just a vehement disagreement, if you're coming from polar-opposite directions, make your position known. But it's not worth spending time on it - especially if you need to work with them on other things. You can disagree without being disagreeable.

Don't pick a fight with them or try to goad them into an argument about something that you already know you're not going to find any common ground on. It's a waste of time for both of you.

What's your bottom line for 2020, then?

Askew: This is going to be a very challenging year, with a highly polarized electorate and sharply divided Congress. So, we have a lot of challenges ahead of us in this environment. But I think that, working in concert with other physician organizations and allying other aligned groups, we'll find a way to accomplish what we need to get done.

MEDICINE'S ADMINISTRATIVE BURDENS CREATE OPENINGS FOR INNOVATION

By: Andis Robeznieks, Senior AMA News Writer

The administrative burdens embedded in the U.S. health care system are so ripe for improvement that they have created a multitude of ways for innovators to make a positive difference.

That's the view of Marijka Grey, MD, MBA. She is executive leader for transformation implementation, physician enterprise, at Catholic Health Initiatives, which recently aligned with Dignity Health to form CommonSpirit Health.

"Instead of concentrating on the patient and what the patient needs at the moment, we're concentrating on the data and the computer," said Dr. Grey, who spoke at the HLTH conference in Las Vegas. The AMA, which is focused on making technology an asset in the delivery of care instead of a burden, was an innovation partner at HLTH and shared how it is helping to drive the future of digital health.

At an earlier presentation, James L. Madara, MD, the AMA's executive vice president and CEO, told attendees that if tech companies want their digital health tools to gain market adoption, their products must work as intended. And for that to happen, physicians must be involved in their initial design, testing and prototype development.

Physicians aren't technophobic

Similarly, Dr. Grey sought to dispel the misconception that physicians are technology phobic.

"Physicians love technology - we are the No. 1 adopters of the newest tech," she said. "We always have the greatest gadgets in our homes.

"But the difference is that the tech we

have at home works for us - the tech we have at the office does not," she added to applause from the crowd. "And if it doesn't work for us, it doesn't work for the patient."

Another panelist was Vivek Garipalli, co-founder and CEO of Clover Health, a company originally built to work with Medicare Advantage (MA) plans to provide physician clinical-decision support. When the company was getting a cold reception, Garipalli and his partners decided to build their own MA plan and asked themselves, "How hard can that be?"

Lessons they learned included going easy on using terms such as "value-based care" and "pay-for-performance," which he said "create a lot of paranoia" among physicians about potentially punitive payment policies.

Instead, Garipalli said physicians who use the Clover decision-support system get "gold card" treatment for "quick and easy" payment or prior authorization decisions. Also, rather than resulting in punitive action toward physicians, instances in which doctors overrule the decision-support system are considered educational. Data from such occasions is collected to inform future recommendations.

Pain points lead to innovation

Other panelists shared their stories of a how a bad situation shaped the companies they founded.

Ali Diab, co-founder and CEO of Collective Health, said he formed his company that supports self-insured employers after he incurred a huge hospital bill and his previous employer's health plan said it would only cover about half of it.

Meanwhile, Pranay Kapadia, acted on the words of his physician wife, who said she sometimes felt like a well-paid data collector. Kapadia launched his startup company, Notable, with a voice-powered Apple Watch app that records spoken data points and enters them into an electric health record.

Dr. Grey noted that she and other primary care physicians need solutions that apply to all their patients.

"I treat the sore knee, I treat the diabetes, I treat the possibility of cancer," she said. "I take care of it all."

If a solution doesn't support all her patients, it could lead to a two-tier system where some patients receive the high-tech, high-touch treatment and others do not.

PATIENT MOVEMENTS COULD HELP DOCTORS REDISCOVER MEDICINE'S JOY

By: Tanya Albert Henry, AMA Contributing News Writer

A patient revolution is brewing, and it's one that will benefit more than patients. It could help decrease physician burnout and revive the joy of medicine too.

During an event at the AMA's Chicago headquarters, a physician from the Mayo Clinic and a senior strategist for the OpenNotes movement spoke about two shifts that are underway to transform health care and emphasized what doctors today need to know about these changes.

One movement is rejecting industrial health care in favor of "careful and kind care for all." The other movement is urging patients to learn more about their health by accessing the notes physicians take during their visits.

Rejecting a transactional system

Today's hurried office visits leave physicians feeling burnt out and patients feeling overwhelmed, endocrinologist Victor M. Montori, MD, told those gathered at the event. He is the author of a book called Why We Revolt: A Patient Revolution for Careful and Kind Care.

Doctors are asked to check off boxes on a computer, taking away time from discussions of what really brought the patient in that day. Patients, meanwhile, are asked to watch educational videos, transmit data, self-measure, self-monitor and self-manage, among many other health care tasks.

Our health system is driven by regulations and incentives instead of integrity. It calls for caring for "patients like this" rather than "this patient" and it wants efficiency, not elegance, said Dr. Montori, who does research at Mayo Clinic's Knowledge and Evaluation Research Unit in Rochester, Minnesota, to advance person-centered care for people with chronic conditions.

"This industrial health care system is unsustainable," he said. "I think it is going to go away either because we are part of the change or the change is going to take us along with it."

The health system needs to support patients and clinicians, not the other way around, Dr. Montori said.

"Health care is not another industrial sector. It is not another sector of our economy. It is not 20% of our GDP. It is more complicated than that. It is people caring for other people. It is us caring for one another. We need to move away from this notion that it is just a transactional

economic deal," he said. "Where we need to be is careful and kind care for all."

Build trust by opening your notes

As momentum builds toward a less industrialized health system, today's patients are looking to be on a level playing field when it comes to their care.

There's a burgeoning movement for patients to have access to their physicians' notes, said Liz Salmi, a patient who has undergone two surgeries for brain tumors in the past decade. She is also a senior strategist for OpenNotes, an international movement that urges doctors, nurses and other clinicians to invite patients to read the notes they write describing the visit.

In October 2016, 11 million patients had access to their clinical notes through existing online patient portals; that number has grown to about 44 million in October 2019, said Salmi.

She shared citations from about 100 studies showing successes when doctors open their notes, including findings that patients who read their doctors' notes feel more engaged in their care, that vulnerable populations become more likely to report increased trust in their doctors, and that there can be an improvement in medication adherence.

A 2011 study, "Inviting Patients to Read Their Doctors' Notes: Patients and Doctors Look Ahead," published in Annals of Internal Medicine, found that after physicians opened up their notes to patients, 99% were likely to feel the same or better about their doctor after reading just one note and 99% wanted continued access to the notes.

"There isn't anything that 99% of people agree upon, but their doctor's notes might be one of them," Salmi said.

The 2011 study also found that:

- Physician worries about negative patient effects do not materialize.
- There is little impact on workflow.
- Email and phone volume is unchanged.
- None of the physicians stopped sharing the notes.

"We're on the threshold of a new era of communications," Salmi said. "Physicians and patients should be leading the way and not leaving it to coders and EHR vendors."

MICHIGAN'S MEDICAID EXPANSION DOUBLES ACCESS TO PRIMARY CARE

By: Andis Robeznieks, Senior AMA News Writer

When Michigan elected to expand its Medicaid coverage, the state customized its program to emphasize primary care and preventive health services. Studies are showing the approach is paying off for patients.

The Healthy Michigan Plan, which now covers residents in households with incomes up to 138% of the federal poverty line, has helped enrollees find a regular source of care other than a hospital emergency department, improved access to and use of preventive services such as cancer screenings, and reduced forgoing needed care because of cost.

"This adds to the evidence that Medicaid expansion improves access to care and the impact of Medicaid expansion on access to preventive and primary care services is something we should take note of," said Susan Goold, MD, adding that patients get more "health for the buck" when they get primary care.

"I'm biased because I'm a primary care doctor, but the research shows this over and over," said Dr. Goold, a professor of internal medicine and health management and policy at the University of Michigan, Ann Arbor. She also previously served as chair of the AMA Council on Ethical and Judicial Affairs.

Dr. Goold and her colleagues surveyed 4,090 Healthy Michigan enrollees and examined preventive services claims data to produce three studies published in the Journal of General Internal Medicine (JGIM).

The JGIM studies stem from independent evaluations of the Healthy Michigan Program that were required under the section 1115 waiver the state received from the Centers for Medicare & Medicaid Services.

The University of Michigan Institute for Healthcare Policy and Innovation was awarded a contract in 2014 to conduct the evaluations, which have resulted in several related reports that have been published in JGIM, JAMA Internal Medicine (April 2018) and other medical journals.

The general finding is that patients report improved health "after being enrolled in Healthy Michigan," said Dr. Goold, the lead author of one JGIM study and a co-author

on the other two.

Affordable care's value

Opponents of Medicaid expansion have argued that increasing eligibility would not necessarily improve patient access to care, Dr. Goold said, but these studies have refuted that argument.

"There is now growing recognition across the political spectrum of the value of being able to afford care," she said. "You can't grow your economy unless people are healthy. Good health helps people gain employment or stay employed."

Key findings of the reports include:

- Of enrollees with chronic conditions, 42% reported having it first identified after their enrollment.
- 52% of those with chronic conditions reported that their physical health improved and 43% said their mental health improved.
- Nearly 90% said they had seen a primary care provider since enrolling.
- 92% said they had a regular source of care since enrolling.
- The percentage of survey respondents who said an emergency department or urgent care center was their regular source of care dropped from 25.3% to 7% after enrollment.
- Nearly 58% said they had not had health insurance in the 12 months before they enrolled in Healthy Michigan.
- One third said they had forgone needed care due to cost or lack of insurance in the 12 months before enrollment.
- More than 70% of women over 50 received a breast cancer screening after enrollment.
- More than half of enrollees over 50 had received a colon cancer screening.
- Nearly 90% said obtaining coverage resulted in lower stress and worry.

"That's pretty remarkable," said Dr. Goold regarding the patient-reported improvements that were seen in only one year.

The expansion does come with strings attached. Similar to Indiana and Iowa Medicaid programs, enrollees are encouraged to complete a health risk assessment (HRA) and commit to healthy behavior, according to one of the JGIM reports. And, like the Indiana and Iowa plans, cost sharing is involved.

Except for preventive services, all enrollees are subject to co-pays and individuals at 100% of the federal poverty line and above pay a monthly "contribution" of around $25. Dr. Goold said that, in reality, it could be considered a "premium."

Almost half of enrollees (49.3%) reported completing the HRA and were then eligible for a financial reward, usually a gift card or reduced co-pay, but most were unaware of an incentive being offered. The most common reason given for completing the HRA (46%) was that their primary care physician suggested it. Of those that completed the HRA, almost 84% said they considered it a valuable tool to improve their health.

Dr. Goold and colleagues reported three important findings in this study:

- Self-reported HRA completion was substantial.
- Physicians and other primary care providers were influential in getting enrollees to complete the HRA and to commit to at least one "healthy behavior" such as improving their diet.
- The financial incentives being offered had little influence.

SOCIAL DETERMINANTS OF HEALTH: WHAT THEY ARE, WHAT THEY AREN'T

By: Andis Robeznieks, Senior AMA News Writer

There is a growing focus on the social determinants of health (SDOH). Yet the term is in danger becoming diluted, and SDOH interventions aimed at individual patients - while beneficial - should be accompanied by broader community interventions that can benefit a larger patient population.

As defined by the World Health Organization (WHO), SDOH are "the

conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems."

Meeting individual and community needs

In recent years, SDOH have been the subject of several studies and essays in JAMA Network™ journals, Health Affairs and a National Academies of Sciences, Engineering and Medicine report. These papers discuss the differences between individual-level "social needs" and community-level "social determinants."

"There is a growing recognition that medical care alone cannot address what actually makes us sick," wrote Brian Castrucci, CEO of the de Beaumont Foundation, and John Auerbach, president and CEO of Trust for America's Health, in a Health Affairs Blog post, "Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health."

Their post discusses how some hospitals and health systems have been addressing the social needs of patients who have been placed at high risk therefore creating high cost.

"While health care leaders have realized that programs to buy food, offer temporary housing, or cover ride-sharing programs are less expensive than providing repeat health care services for their highest cost patients, such patient-centered assistance does not improve the underlying social and economic factors that affect the health of everyone in a community," Castrucci and Auerbach wrote. "While targeted, small-scale social interventions provide invaluable assistance for individual patients, we must also remain focused on the social determinants that perpetuate poor health at the community level."

Public health and clinical strategies

Kirsten Bibbins-Domingo, MD, PhD, chaired the National Academies consensus committee that produced the report "Integrating Social Care Into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health," and she summarized the panel's work in a JAMA Viewpoint column.

Five different activities related to integrating social care into health care were noted by Dr. Bibbins-Domingo, who chairs the Department of Epidemiology and Biostatistics at the University of California San Francisco. They cover a range from the individual and community solutions others discussed and include:

- Awareness, which involves asking people about their access to transportation.
- Adjustment, such as reducing the need for in-person care by using telehealth technology.
- Assistance, such as providing vouchers for ride sharing or public transit.
- Alignment, which includes investing in community ride-sharing programs.
- Advocacy, such as working to fundamentally change a community's transportation infrastructure.

The National Academies' report lists five things that should be done "to achieve integration of social care into health care."

According to the report, it is necessary to:

- Design health care delivery to integrate social care into health care.
- Build a workforce to integrate social care into health care delivery.
- Develop a digital infrastructure that is interoperable between health care and social care organizations
- Finance the integration of health care and social care.
- Fund, conduct, and translate research and evaluation on the effectiveness and implementation of social care practices in health care settings.

Also worth reading: "Upstream Communication Toolkit: Tools to improve communication about social needs and social determinants of health," released by the Burbank, California-based physician-run advisory firm HealthBegins.

continued on next page

WHAT LEGAL CHALLENGES WILL AFFECT PATIENTS AND PHYSICIANS IN 2020?

By: Tanya Albert Henry, Contributing AMA News Writer

The AMA and the Litigation Center of the American Medical Association and State Medical Societies are poised for another busy year of being the voice of America's medical profession in state and federal courts.

Through lawsuits, amicus briefs and other efforts, the AMA and the AMA Litigation Center pursue cases that are important to physicians and their patients. Brian D. Vandenberg, senior vice president and general counsel at the AMA, recently talked about what's ahead in the legal arena this year.

Tanya Albert Henry: As we head into 2020, what do you see as the biggest medicolegal trends that physicians should keep their eyes on?

Brian Vandenberg: Physicians are increasingly burdened by third-party interference with the practice of medicine and patient care, by the government and by insurance companies. Government efforts to use physicians as mouthpieces to advance political agendas, under the guise of informed consent, will continue to be challenged in the courts as violations of physician-patient free speech.

And, I believe, interference in the form of prior authorization, step therapy and coverage denial will face increasing legal scrutiny. I also expect that issues impacting access to care will trend in 2020.

Henry: Are these a continuation of what physicians have seen in 2019, or new things on the horizon in 2020?

Vandenberg: These issues aren't new, but I expect intensified focus in 2020 as existing cases make their way through the courts, as new challenges are brought and as health care is a key issue in 2020 elections.

Henry: The AMA has been fighting against "hybrid" medical liability lawsuits. Why do you think these are on the rise, and how's the AMA working to combat the trend?

Vandenberg: Hybrid liability suits attempt to disregard medical malpractice liability caps by conflating distinct legal theories, an end-run around legislative tort reform. On the one hand, they are inevitable, as tort-reform opponents seek new ways to overcome caps on noneconomic damages in medical malpractice lawsuits.

On the other hand, they are disingenuous - a dangerous invitation for courts to trample on legislative authority. We'll continue to advocate for meaningful tort reform, and will continue to challenge and file amicus briefs in abusive hybrid lawsuits.

Henry: The AMA has been active in the courts to protect the sanctity of the patient-doctor relationship and the importance of open, honest discussion in the exam room. Are there other trends you see in this space where the AMA might be getting involved?

Vandenberg: Yes. One can imagine any number of contexts in which government intrusion on the patient-physician relationship jeopardizes patient privacy, trust and care. The government doesn't belong in the exam room, period, whether in the context of family planning or any other context. Patients need to able to trust their physicians, and we need to always make sure that doctors are working for their patients and not for the government. We'll always fight to ensure that patients are not robbed of this trust.

Henry: What do you see as the biggest cases for physicians to follow in 2020?

Vandenberg: The biggest case to follow is clearly Texas v. United States (aka Texas v. Azar), which challenges the constitutionality of the Affordable Care Act and impacts access to care for tens of millions of Americans. We'll remain active in arguing for the continued viability of the ACA.

Also, our challenge to the federal Title X "gag rule" in AMA v. Azar is important to follow. Its importance is not only in challenging a new rule that guts one of the most successful federal health programs in history, but also because the new Title X rule invites the government into the exam room, an unacceptable intrusion on the patient-physician relationship.

Henry: What is the potential impact of each case to physicians and to the practice of medicine?

Vandenberg: Access and trust. It's really that simple.

Henry: What do you think is most commonly misunderstood by physicians about the work of the AMA Litigation Center?

Vandenberg: What's most misunderstood is likely the volume and scope of cases in which the AMA is engaged, advocating for physicians and patients in courts on issues that are essential to patient care. We're currently involved in more than 60 lawsuits across the country, on issues ranging from health economics to health equity.

Health Department

Macomb County Health Department
Reportable Diseases Summary
Diseases Reported in Macomb County Residents*

Cumulative total for previous years; year-to-date total for December[b], 2019

	2019	2018	2017	2016	2015
AMEBIASIS	1	0	0	1	0
BLASTOMYCOSIS	0	0	0	1	0
BOTULISM (FOODBORNE)	0	0	0	0	0
BOTULISM (INFANT)	0	0	0	0	0
BRUCELLOSIS	0	0	0	0	0
CAMPYLOBACTER	144	138	120	96	79
CHICKENPOX	63	41	31	33	32
CHLAMYDIA	2,713	3,586	3,598	3,185	2,736
COCCIDIOIDOMYCOSIS	1	4	2	2	2
CREUTZFELDT JAKOB	0	2	2	2	2
CRYPTOCOCCOSIS	1	4	1	1	1
CRYPTOSPORIDIOSIS	6	12	6	10	1
CYCLOSPORIASIS	1	1	12	2	0
DENGUE FEVER	1	0	0	1	1
DIPHTHERIA	0	0	0	0	0
EHRLICHIOSIS	0	0	0	3	0
ENCEPHALITIS PRIMARY	2	2	4	1	2
ENC POST OTHER	3	2	1	1	1
FLU-LIKE DISEASE	21,049	23,444	28,172	21,747	27,943
GIARDIASIS	24	9	20	23	17
GONORRHEA	930	1,093	946	801	522
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	10	10	9	10	4
H. FLU INVASIVE DISEASE	16	11	21	14	11
HEMOLYTIC UREMIC SYN.	2	0	0	0	0
HEPATITIS A	2	33	201	9	5
HEPATITIS B (ACUTE)	3	5	5	9	6
HEP B (CHRONIC)	97	102	108	110	125
HEPATITIS C (ACUTE)	21	31	49	31	16
HEP C (CHRONIC)	498	857	898	931	673
HEPATITIS D	0	1	0	0	0
HEPATITIS E	0	1	0	0	0
HISTOPLASMOSIS	4	3	0	5	5
HIV^	55	75	69	57	64
INFLUENZA	5,031	7,570	4,136	2,164	1,143
KAWASAKI SYNDROME	4	3	5	5	10

	2019	2018	2017	2016	2015
LEGIONELLOSIS	75	102	56	34	25
LISTERIOSIS	4	3	3	1	1
LYME DISEASE	7	8	5	3	5
MALARIA	0	2	2	2	2
MEASLES	0	0	1	0	0
MENINGITIS VIRAL	45	61	44	43	60
MENINGITIS BACTERIAL/BACTEREMIA *(EXCLUDING N. MENINGITIDIS)*	5	18	11	9	10
MENINGOCOCCAL DISEASE	0	0	0	1	1
MUMPS	3	2	3	2	0
PERTUSSIS	24	48	81	37	35
POLIO	0	0	0	0	0
PSITTACOSIS	0	0	0	0	0
Q FEVER	0	0	0	0	0
RABIES ANIMAL	1	4	2	1	1
RABIES HUMAN	0	0	0	0	0
REYE SYNDROME	0	0	0	0	0
ROCKY MNTN SPOTTED FVR	0	2	0	1	0
RUBELLA	0	0	0	0	0
SALMONELLOSIS	66	82	75	78	82
SHIGELLOSIS	21	10	46	50	22
STEC**	16	24	10	7	9
STREP DIS, INV, GRP A	38	47	32	31	27
STREP PNEUMO, INV + DR	56	54	45	55	52
SYPHILIS	83	145	84	79	108
SYPHILIS CONGENITAL	0	3	1	0	2
TETANUS	0	0	0	0	0
TOXIC SHOCK SYNDROME	1	1	0	0	1
TUBERCULOSIS	5	5	10	11	6
TULAREMIA	0	0	0	0	0
TYPHOID FEVER	2	0	0	0	1
VIBRIOSIS	0	2	0	1	0
VISA	1	2	1	0	0
WEST NILE VIRUS	2	11	7	2	4
YELLOW FEVER	0	0	0	0	0
ZIKA	0	0	0	4	0

*Includes both Probable and Confirmed case reports.

**Shiga-toxin producing Escherichia coli per MDHHS; combo of E. coli & Shiga Toxin 1 or 2.

6-Feb-20

^ Previously reported as "AIDS"

[b] 2019 total is tentative at this time.

March/April 2020
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2019-2020
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