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Our Planet Has a Fever, Should We Be Concerned?



By: Lawrence Handler, MD
MCMS President

DEAR FELLOW
COLLEAGUES,

As we enter the Holiday season, I want to take this opportunity to wish all of our members and families much joy and good health.

This forum and political year has provided me ample opportunity to dwell on many issues. The climate change discussion is an example that should take on critical importance, yet, this does not seem to have political consensus or any hope for bipartisan analysis.

We are enjoying this glorious Michigan Fall. Overall, the weather has been ideal and for the moment we will try to forget “climate change” as we enjoy our Fall colors. Yet, unbeknownst to most of us, in terms of climate, we are living in historic times. The summer of 2016 was fantastic in terms of weather. Should we be worried that we have experienced record temperatures? The National Oceanic and Atmospheric Administration (NOAA) reported 2016 temperatures at a record average and the highest in a period dating back to 1880. The 2016 average temperature surpasses the previous historic records from 2015. The Ocean temperatures are also at record levels and the Arctic Circle is melting.

Recently, my family and I traveled to Glacier National Park located on the border between Montana and Canada. Prior to our trip based on the name, our assumption was an opportunity to see GLACIERS. From the South end of the park they are barely visible and only if the sky is clear and you tilt your head the proper angle and look between several mountain ranges. Park rangers explained, that based on the current rate of ice melt, that it is very likely glaciers will be extinct in Glacier National Park within 20-30 years. Think about that—after tens of thousands of years we are living at a time that will likely see the end of glaciers in the United States. The environmental impact is predicted to be significant. Should that worry us? Or do we dismiss this as normal natural climate cycles.

Just as vivid as the Glacier ice melt in the United States are many other examples—including the increased rate of the ice melt on Greenland and the Arctic Circle along with documented rising sea levels. Today, there are several island countries facing a threat to their existence, because of just a small rise in the ocean levels. This discussion is not limited to the potential environmental impact, but also has significant political implications. Countries bordering the Arctic Circle have begun posturing to claim territorial rights. Conflicts between countries regarding potential new shipping routes,

Climate change concerns should not be a Democratic or Republican issue, but a bipartisan issue.

mineral rights and energy resources could cause future military conflicts to occur, which is directly related to the Arctic ice melt.

Climate change concerns should not be a Democratic or Republican issue, but a bipartisan issue. However, the term climate change has become so politically charged it is difficult to see a change to this conversation. My suggestion is to rename this from “climate change” to “climate concern”. Maybe this will reset the politics to allow for a more in depth examination of what many see as a critical global issue.

I spend my day, looking for subtleties when taking a history and doing a physical examination. Sometimes these “clues” pan out to be significant and at times are just normal physical variants. I firmly believe there is enough climate “clues” that deserves our attention. There is no downside to early detection, but hopefully with our climate and environment we still have that option.



MSMS BOARD TALKS SB1019, BCBSM, SIM, CPC+ AT MEETING

In early October, the Michigan State Medical Society (MSMS) Board of Directors heard from Thomas L. Simmer, MD, regarding Blue Cross Blue Shield of Michigan's activities and priorities for the upcoming year, discussed the State Innovation Model (SIM) and Comprehensive Primary Care Plus (CPC+), discussed legislative issues, and reviewed and approved MSMS's 2017 budget.

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

- **Senate Bill 1019:** Senate Bill 1019 removes the requirement for physician supervision for anesthesia services. In spite of routine mischaracterizations of what this bill would actually do, in spite of numerous concerns brought forward by a number of individual senators, and in spite of significant lobbying efforts on the part of the physician community, the legislation was once again moved through the Senate without any changes. SB 1019 has been referred to House Health Policy, to which Representative Mike Callton chairs. MSMS has met with Representative Mike Callton on this issue, and he is frustrated that this legislation has found its way to his committee without sufficient deliberation in the Senate, and that his committee is now tasked with unraveling this complex issue after the Senate largely ignored their obligations. Furthermore, the Representative has indicated that he does not like addressing issues that are needlessly controversial among groups that he is traditionally aligned with. Chairman Callton has indicated that he may be inclined to hold a hearing on the legislation, but does not support the bills and does not believe that there is support to pass the bills. Physician contact with legislators over the next several months will be crucial.
- **Senate Bill 1104:** Introduced by Senator Mike Shirkey (R-Clark Lake), Senate Bill 1104 clarifies the requirements for economic damages in professional liability cases. The MSMS Board of Directors voted to support SB 1104, which is comprehensive in providing a fix to the Greer v. Advantage Health case that will provide the Michigan Court of Appeals with the necessary statutory authority to rule that plaintiffs are only entitled to the actual damages and not the windfall that comes from calculating losses based on hospital charges.
- **Blue Cross Blue Shield of Michigan:** Thomas L. Simmer, MD, Vice President and Chief Medical Director of Blue Cross Blue Shield of Michigan spent significant time highlighting BCBSM's activities and priorities for the upcoming year. Those include:
 - Patient Centered Medical Home (PCMH) and Physician Group Incentive Plan (PGIP): PGIP now includes more than 20 initiatives with nearly 20,000 primary care physicians and specialists participating. 4,534 physicians and 1,638 practices have been designated as PCMH in 2016.
 - Value-based Reimbursement for Primary Care and Specialists: 77 percent of PGIP primary care physicians and 62 percent of PGIP specialists are receiving value-based reimbursement. \$57.1 million was paid to primary care physicians, \$45.7 million was paid to specialists in 2015 for value-based reimbursement. Ten years ago, MSMS strongly advocated for the adoption of this incentive program, benefiting its members.
 - Hip and Knee Bundled Payment Program: Full scale launch will begin January 1, 2018 with a limited launch date of July 1, 2017. This will be a customer specific offering initially with retired and salaried automotive employees. The program is being offered to all providers within network.
 - New Precertification Program: BCBSM has three new precertification programs (or prior authorization) for radiation therapy, lumbar spine fusion and interventional pain. There was robust discussion around BCBSM's history of collaborative quality initiatives to improve quality in contrast to a more short-term and perhaps short-sided utilization management program like pre-authorization. BCBSM was encouraged to consider using outcomes to allow high-quality performers to be rewarded not monetarily but by "graduating" out of the program.
 - Personal Choice PPO: This new BCBSM product uses the Organized System of Care (OSC) program. The network is tiered into level 1 OSCs, level 2 OSCs, the PPO network, and





out-of-network. Tiers were determined by cost. Member cost sharing is also tiered.

- **State Innovation Model (SIM) and Comprehensive Primary Care Plus (CPC+):** Under SIM, the Michigan Department of Health and Human Services opted for a custom payment model rather than CPC+. MDHHS recommended that all practices previously participating in MiPCT apply for participation in CPC+ as a way to continue much needed funding for chronic care and care coordination services. MSMS continues to work with Physician Organizations, as well as BCBSM and Priority Health, as the commercial plans participating in CPC+.
- **MSMS Submits Comments to MDHHS on SIM Custom Payment Option:** MSMS, with input from its partners on the Executive Council of Physician Organizations, drafted a number of recommendations to address the challenges and improve the chances for successful SIM implementation. The recommendations centered on the need for greater simplicity and alignment across payment models between Medicare, Medicaid, and commercial payers in Michigan. MDHHS recently announced it would accept the recommendations of MSMS and incorporate a significant portion of these items into its customer payment option design.
- **Drug Diversion:** The MSMS Board of Directors spent a great deal of time discussing the issue of drug diversion. MSMS has a fair amount of policy in this area that exists from a series of House of Delegates resolutions, positions on legislation, as well as ongoing input from the Task Force at MSMS chaired by Pino Colone, MD. MSMS has been very active in being a constructive partner with legislators and law enforcement to take meaningful steps to reduce drug diversion and avoid overly burdensome requirements for physician practices that will not reduce addiction or drug related deaths. Specifically, MSMS has been prioritizing the following areas:
 - Broaden access to naloxone
 - Improve MAPS-Improve functionality and reduce workflow burdens
 - Advocate for funding for State of Michigan to offset cost of EHR integration
 - Enhance existing regulatory pathways to address bad actors as opposed to adding more requirements onto physicians that are obeying the law.
 - Improve options and capacity for treatment programs
 - Update and enhance educational offerings to physicians related

to pain management and drug diversion issues

- Only consider MAPS related mandates if uptake is still too low, and limit mandates to only instances where such checks would be clinically indicated. Consider laws similar to Massachusetts for prescriptions that exceed a seven day supply.

Finally, Mark Komorowski, MD, made a plea for all physicians to donate \$100 to the Michigan Doctors' Political Action Committee (MDPAC). Supporting MDPAC protects your patients and the medical profession through pro-medicine candidates. In a matter of personal privilege, Doctor Komorowski said "...the APRN bill affects everyone ... the CRNA bill ... these are reasons enough to donate to MDPAC. If everyone gave a one-time \$100 donation to MDPAC in 2017, we will stop asking for money for three years. Please donate today."

CMS UNVEILS HIPAA COMPLAINT AND TESTING WEBSITE

The Centers for Medicare & Medicaid Services (CMS) released an updated website where providers and others can lodge complaints against



a HIPAA covered entity (including health plans and clearinghouses) for potential non-compliance with the administrative simplification provisions of HIPAA and the Affordable Care Act. The Administrative Simplification Enforcement and Testing Tool (ASETT) enables individuals or organizations to file a complaint in the areas of electronic transactions and supporting operating rules (such as electronic funds transfer), medical code sets such as ICD-10, and unique identifiers (i.e., national provider identifier). The ASETT system captures required demographic information about the complainant and the filed-against entity, details of the alleged violation, and any supporting documentation. When filing a complaint, the complainant has the option to remain anonymous to the filed-against entity.

This ASETT system also facilitates testing of HIPAA 5010 electronic transactions and operating rules for compliance, syntax, and business rules. In addition, providers can validate code values against 60-plus clinical and non-clinical code sets, including ICD-10 diagnostic and inpatient procedure code sets. CMS would then reply with acknowledgment transactions and reports to help identify and resolve errors.



DO NOT IGNORE: NEW NON-DISCRIMINATION REQUIREMENTS

Physicians accepting Federal financial assistance from the US Department of Health and Human Services (HHS) including, but not limited to, payment under any Medicare Part A, C, and D plan or Medicaid must comply with the provisions under Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive federal assistance.

Effective July 18, 2016, physicians must:

- Post a nondiscrimination notice in the office and on the practice website.
- Post “taglines” in the office and on the practice’s website indicating that language assistance services are available free of charge.
- Taglines must be made available in the 15 most common languages spoken in Michigan. You will only need to add the correct phone number. The top 15 non-English languages for Michigan are: Spanish, Arabic, Chinese, Syriac, Vietnamese, Albanian, Korean, Bengali, Polish, German, Italian, Japanese, Russian, Serbo-Croatian, and Tagalog.
- Arrange for translator services or make other reasonable accommodations if necessary and requested. Some health plans you contract with arrange for these services at no charge. You should contact the health plans you contract with to inquire if services are available. If a translator service is necessary, you will be responsible for any associated costs and may not bill the patient. Other reasonable accommodations that may be appropriate in certain situations include remote or other electronic translation and preprinted written translations.
- Print the 15 taglines on any of your significant publications and communications. On smaller items such as postcards and brochures you may print just Spanish and Arabic. You may first use up existing stock of pre-printed publications.

Although the enforcement date for the posting provisions is delayed until October 17, 2016, best practice protocol is to incorporate these requirements as soon as possible. It is also important that your existing compliance program be updated to include training for physicians and staff on these nondiscrimination regulations and protections. Training materials, a model grievance procedure, and frequently asked questions are available on the HHS Office of Civil Rights website. Physician practices with 15 or more employees are required to have a grievance procedure and a designated compliance coordinator.

The Michigan State Medical Society’s Legal Counsel is preparing a comprehensive Legal Alert outlining the requirements of Section 1557. In the interim, please do not hesitate to contact Stacey Hettiger at (517) 336-5766 with your questions.

If you are looking to contract with a vendor for your compliance needs, MSMS Practice Solutions partner, First Healthcare Compliance®, offers multiple options from which to choose and a discount for MSMS members. Visit www.1sthcc.com/michstatedmedsoc

MSMS FOUNDATION TO HOST CONFERENCE ON HEALTH CARE COMPLIANCE

The Michigan State Medical Society (MSMS) Foundation will present a conference titled Practical Guidance for Health Care Compliance on Thursday, December 8 at the MSMS Headquarters in East Lansing from 10 am - 3 pm. Physicians and members of their office staff will hear experts address the following topics:

- Understanding Medicare Payment Reform
- Making MACRA Work for You
- Meeting Deadline Challenges
- Tackling Everyday Compliance Questions

Across the board, health care compliance concerns face every practice no matter what the specialty or practice setting. The MSMS Foundation’s Practical Guidance for Health Care Compliance is designed to help bring order to the current regulatory environment and offer practical guidelines to ensure a medical practice is compliant. The Practical Guidance for Health Care Compliance conference allows physician attendees to earn up to 4 AMA PRA Category 1 Credit(s)[™] during this one-day event.

To register or for more information on the MSMS Foundation’s Practical Guidance for Health Care Compliance conference, please visit www.msms.org/EO.

BLUE CROSS BLUE SHIELD OF MICHIGAN DESIGNATES RECORD NUMBER OF PHYSICIAN PRACTICES AS PATIENT-CENTERED MEDICAL HOMES

For the eighth consecutive year, Blue Cross Blue Shield of Michigan and its physician partners are leading the nation in advancing the patient-centered medical home model of care, as 1,638 practices,



comprised of 4,534 physicians, have earned designation as patient-centered medical homes. This medical home model has reduced both hospitalizations and emergency visits, resulting in improved health outcomes and preventing \$427 million in medical costs over six years.

“Now in our eighth year of designation, this model of care has matured to a point where a majority of primary care physicians who participate with Blue Cross now embody the qualities of the patient-centered medical home model,” says former MSMS Board Chair David Share, MD, MPH, senior vice president, Value Partnerships. “Together, Blue Cross and our provider partners have firmly established this advanced care model throughout Michigan. In fact, there is at least one Blue Cross-designated patient-centered medical home in 80 of Michigan’s 83 counties.”

The benefits of the patient-centered medical home model reach all of a practice’s patients, regardless of whether the patient is insured by Blue Cross, because physician practices follow the PCMH approach for their entire patient populations.

PCMH practices offer 24-hour access to the care team. They coordinate specialist care and other therapies. They also teach patients how to manage conditions like asthma and diabetes.

Data from 2016 show that Michigan Blue Cross PCMH practices have patients who require fewer hospital admissions and emergency room visits than patients in non-designated practices. For example, adult patients in Blue-designated PCMH practices had a 21.4 percent lower rate of hospital admissions for certain conditions than non-designated practices. These are examples where appropriate care in the primary care physician’s office or clinic prevents a medical condition from worsening.

Blue Cross-designated PCMH practices also had an 8.7 percent lower rate of adult high-tech radiology use, a 15.1 percent lower rate of adult ER visits and a 17.2 percent lower rate of pediatric ER visits.

“The PCMH model also encourages primary care physicians to coordinate with specialists, and with providers at other facilities such as hospitals or outpatient centers. This coordination greatly contributes to an improved patient experience, and health outcomes,” says Doctor Share.

PCMH designation lasts for one year, July through June.

The PCMH initiative is part of Value Partnerships, a collection of collaborative initiatives among physicians, hospitals and Blue Cross, all aimed at improving quality and outcomes of health care in Michigan. To learn more, please visit valuepartnerships.com.

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Henry Ford Macomb Hospital

CANCER PATIENT ART SHOW SHOWCASES WORKS DONE BY INFUSION PATIENTS

More than two dozen paintings, photographs and drawings created by cancer patients undergoing chemotherapy were on display during a special Cancer Patient Art Show at Henry Ford Macomb Hospital held Oct. 12.

Guided by an art therapist, chemotherapy patients use drawing, painting and other artistic expressions to help manage the emotional and psychological side effects that often result from cancer diagnosis and treatment. The program is made possible by a grant from The Zoe Foundation for Infusion Art Therapy. The hospital also hosts a monthly Art Therapy Support Group for anyone in the community who has been touched by cancer.

For information about the art therapy program, please call (586) 263-2230.



HENRY FORD MACOMB HOSPITAL RECEIVES \$4 MILLION GIFT FOR EXPANDING SURGICAL SERVICES

In late September Henry Ford Macomb Hospital announced a \$4 million donation from Macomb County businessman Wayne Webber and his wife Joan.

The gift will help fund an expansion of the hospital's surgical services and newly created Wayne and Joan Webber Department of Surgery. A key feature of the expansion is a hybrid operating room for cardiovascular surgery, a first-of-its-kind in Macomb County.

A hybrid cardiovascular surgical suite is equipped with medical imaging devices like CT or MRI scanners, providing surgeons with real-time information that results in more accurate, advanced treatment and safer, shorter procedures. The expansion also includes:

- Increasing the size of current operating rooms from 400 square feet to 650 square feet.
- Redesigning surgical patient and visitor rooms.

The expansion is essential to meeting the future health care



From left, Tony Rubino, campaign co-chair; Steven Harrington, MD, medical director, Henry Ford Macomb Cardiac Surgery; Wayne and Joan Webber; Barbara Rossmann, Henry Ford Macomb Hospital president and CEO.

needs of Macomb County residents, says Henry Ford Macomb President and CEO Barbara Rossmann.

"We are grateful to Wayne and Joan Webber for their generous gift and support," says Rossmann. "Expansion of the operating



space and accompanying services is critical for providing the highest possible care to our patients, while ensuring we can continue to recruit, retain and educate top surgeons in our region.

“Just 15 years ago, it would have been difficult to imagine cardiac surgery being performed without actually opening the chest, or a hip being replaced and the patient being sent home the next day. We’ve been fortunate to have nation-leading surgeons who have brought these types of advances here - but many of these new options require more space and technology.”

“My wife and I have been very blessed, and it is an honor to share these blessings with Henry Ford Macomb Hospital,” says Wayne Webber, who resides in Chesterfield Township.

After serving 20 months in the U.S. Army during a peacekeeping mission in Korea, Webber took out a \$2,250 loan for a pick-up truck and materials needed to start a new concrete business. He later asked his grade school friend, Earl Champagne, to join him as a partner to form Champagne-Webber, Inc., a small concrete business that eventually grew into a major heavy highway construction company.

The company built highways, bridges, and airport runways in several states. Champagne retired in 1991, and the company’s name was changed to W.W. Webber, Inc. W.W. Webber, Inc. continued to grow to become a successful national highway construction company. W.W. Webber, Inc., along with several affiliate entities, were sold in 2005 and continue to operate today under the name Webber LLC.

The Webber Foundation seeks to provide access to quality healthcare, improve K-12 inner city education, and nourishment, clothing and shelter for the less fortunate.

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St. John Macomb Oakland Hospital



SJMOH 50th anniversary attendees celebrate at home plate.

ST. JOHN MACOMB-OAKLAND HOSPITAL, WARREN CELEBRATES 50 YEARS OF CARING FOR THE COMMUNITY

On Sept. 28, St. John Macomb-Oakland Hospital, Warren, hosted a special event at Jimmy John Field in Utica to commemorate the hospital's 50th anniversary. Community partners, local officials, hospital leadership, physicians and SJMOH associates with more than 40 years of service (current and retired), gathered together for a night of music, food and memory sharing! Congressman Sander Levin submitted a proclamation honoring SJMOH as a long-standing fixture in Macomb County.

ST. JOHN MACOMB-OAKLAND RESIDENT HONORED BY MICHIGAN ASSOCIATION OF OSTEOPATHIC FAMILY PHYSICIANS

St. John Macomb-Oakland Hospital's Joseph Kimbell, DO, was named Resident of the Year by the Michigan Association of Osteopathic Family Physicians. Dr. Kimbell is a third-year resident in family medicine. He believes that family medicine has always meant being an avid fighter for the patient's health and well-being, while also making an impact in the community. Dr. Kimbell has not only been a leader in his residency but also in the community. He has participated in global health trips to Peru, Guatemala and South Africa.

ST. JOHN MACOMB-OAKLAND LEADERS INDUCTED INTO THE MACOMB HALL OF FAME

On Sept. 22, the Macomb Foundation inducted St. John Macomb-Oakland Hospital (SJMOH) President Terry Hamilton and SJMOH physician, Dr. Richard Klein into the Macomb Hall of Fame, among several distinguished community and business leaders. The Macomb Hall of Fame honors individuals and organizations that have made outstanding contributions to improving the economic, family and community life of Macomb County. More than 77 area leaders have been inducted since the Macomb Hall of Fame was founded in 2000. The Foundation's mission is to promote the advancement of business and community in Macomb County.



Macomb Hall of Fame 2016 inductees, including Terry Hamilton (fourth from right) and Dr. Richard Klein farthest right, pictured.



ST. JOHN MACOMB-OAKLAND HOSPITAL, WARREN RECEIVES LEVEL III TRAUMA VERIFICATION

St. John Macomb-Oakland Hospital, Warren, has received verification as a Level III Trauma Center from the American College of Surgeons for 3 years through April 26, 2019. As a Level III Trauma Center, SJMOH provides 24-hour immediate coverage by physicians and a team of specialized surgeons. SJMOH has the ability to initiate immediate lifesaving care for injured patients without delay. This includes availability of surgeons in specialized areas such as orthopedics, neurosurgery, hand surgery, and facial trauma. Studies have shown that patients treated at trauma centers have decreased rates of complications.



**AMERICAN COLLEGE OF SURGEONS
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SJH&MC IMPLANTS FIRST DISSOLVING HEART STENT

St. John Hospital & Medical Center is one of the first in the country to treat patients using a new dissolving heart stent. The Abbott Laboratories' biodegradable stent-Absorb™, was recently approved by the FDA. The heart care team, led by SJH&MC Chief of Cardiology Thomas Lalonde, MD, implanted the new stent in mid-July. Like a dissolving suture, this stent disappears, typically within two to three years. By dissolving after unblocking a clogged artery, the treated artery can pulse and flex naturally as demands on the heart change with everyday activities. It is designed to offer the artery opening benefits of a traditional stent without some of the possible long-term concerns connected with a small percentage of metal stents.

CRACCHIOLO FAMILY COMMITS LEAD GIFT TO SJH&MC BIRTHING CENTER

Longtime St. John Providence supporters, Peter T. Cracchiolo and the Cracchiolo family, have generously committed the lead gift to support the Birthing Center at St. John Hospital & Medical Center. This lead gift from the Peter J. and Constance M. Cracchiolo Foundation is part of a \$6 million total renovation that will enhance the labor-delivery-recovery-postpartum (LDRP) birthing suites and 5-West. In recognition of the gift, the Birthing Center will be named in memory of the late Peter J. and Connie Cracchiolo.

NEW CHAIR OF FAMILY MEDICINE AT ST. JOHN HOSPITAL & MEDICAL CENTER

Effective Aug. 1, Rachel O'Byrne, MD, was appointed Chair of Family Medicine at St. John Hospital & Medical Center. Dr. O'Byrne began her career at St. John Providence in 2005, as a faculty physician of St. John Family Medicine Residency at Masonic Medical Center. She holds several leadership positions, including: SJH&MC Executive Committee member, Student Clinical Coordinator for Central Michigan University and St. Georges University, SJH&MC Adult Practice Performance Committee member, and Chairwoman of the St. John Family Medicine Clinical Competency Committee. In addition, Dr. O'Byrne is a lecturer and preceptor of clinical students at Wayne State University, St. Georges University and Central Michigan University. She has presented on numerous topics and been involved in research activities at SJH&MC and throughout the region.

SJH&MC PATHOLOGIST STUDIES POST-WAR IRAQ'S MEDICAL EDUCATION, EARNS MASTER'S DEGREE

Congratulations to Basim M. AL-Khafaji, MB ChB, MHPE, MIAC, FCAP, a St. John Hospital & Medical Center pathologist, who successfully completed with Distinction, a master's degree, in health professions education (MHPE) by Keele University, UK, and FAIMER, USA (Foundation of Advancement of International Medical Education & Research.) The FAIMER-Keele master's degree is a three-year program for health professions educators who aspire to advance health professions education at their institution and worldwide. Dr. AL-Khafaji's master thesis: "Post Conflict Revitalization of Medical Education: Iraq 2003 and beyond," involved a major review of the most current data regarding medical education in Iraq. The study is currently submitted for publication, with interest by the local authorities, World Health Organization, ACGME-International Division, and the World Federation of Medical Education.



AMPUTATION PREVENTION CENTERS HOSTS RECENT PODIATRY SYMPOSIUM

Lee Rogers, DPM, medical director of Amputation Prevention Centers of America® hosted an evening with several of the podiatric residency programs in Michigan in September including Genesys Regional Medical Center, St. John Hospital

CALL FOR MCMS OFFICER NOMINATIONS

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

The MCMS Board meets approximately 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 held in the Spring.

Anyone interested in running for a position on the MCMS Board please contact Heidi Leach at mcms@msms.org or call 810-387-0364.

HOSPITAL NEWS *continued*

& Medical Center, St. John Macomb-Oakland Hospital, Providence-Providence Park Hospital and Michigan Surgical Hospital. The residents and their directors gained valuable knowledge on how to begin a successful career in advanced wound care and amputation prevention.



In support of PAD Awareness Month in September and The Save a Leg, Save a Life Foundation, the group participated in the national White Sock Campaign, a fun and easy way to make people aware of the importance of early detection of peripheral arterial disease in order to avoid amputation. Shown (l-r) are: Lee Rogers, DPM; Matthew Andrews, DPM; Joshua Rhodenizer, DPM; David Taylor, DPM; Andrew Cohen, DPM; Kyle Sundblad, DPM; Guy Pupp, DPM; and Tom Davis, MD.

ST. JOHN HOSPITAL & MEDICAL CENTER, THE ALLIANCE3 HOST SERBIAN ROYAL COUPLE

Serbian Crown Prince Alexander and Crown Princess Katherine visited St. John Hospital & Medical Center (SJH&MC) in late September as part of a medical mission trip to learn more about combatting hearing loss and the medical resources available to help deaf children. The royal couple were the guests of Daniel Megler, MD, president, Lakeshore ENT, and Ardis Gardella, president, The Holley Institute, a non-profit associated with SJH&MC that provides services and education to the Deaf and hard of hearing. For the past two years, Dr. Megler and Ardis have

collaborated with the royal couple who are devoted to charity work and have a special interest in helping children with hearing loss.



Pictured (l-r): Dr. Xeanakis, Crown Princess Katherine, Crown Prince Alexander, Ardis Gardella, Bob Hoban, SJH&MC president, and Dr. Daniel Megler. The royals' weekend visit also included a fundraiser for The Alliance3 (Lakeshore ENT, Michigan Ear Institute and The Holley Institute) an organization that has been working to share research, physician training and program development for hearing health internationally.

ST. JOHN MACOMB-OAKLAND HOSPITAL RECEIVES AMERICAN SOCIETY OF GASTROINTESTINAL ENDOSCOPY CERTIFICATION

St. John Macomb-Oakland Hospital received its three-year recognition certificate from the American Society of Gastrointestinal Endoscopy (ASGE). The ASGE Endoscopy Unit Recognition Program honors units that have demonstrated a commitment to delivering quality and safety as reflected in their unit policies, credentialing, staff training and competency assessment, and quality improvement activities. SJMOH is now one of only 8 in the state of Michigan to maintain this certification. Congratulations to the SJMOH Endoscopy Center staff for their commitment in delivering safe, high quality patient care.

Electronic Health Record Malpractice Risks

By: David B. Troxel, MD, Medical Director, Board of Governors

THE DOCTORS COMPANY SUPPORTS THE INTEGRATION OF THE ELECTRONIC HEALTH RECORD (EHR) INTO MEDICAL PRACTICES AND BELIEVES IT HAS GREAT POTENTIAL TO ADVANCE BOTH THE PRACTICE OF GOOD MEDICINE AND PATIENT SAFETY. However, there are always unanticipated consequences when new technologies are adopted - and the EHR is no exception. There are real and potential liability risks, and it is important for physicians to become familiar with them.

1. Doctors are responsible for medical information they can access - and there is increased access to e-health data from outside the practice that can be accessed from the practice EHR or website or through Health Information Exchanges, e.g., hospital charts, consultants' reports, lab results and radiology reports, and community medication histories. EHR metadata documents what was accessed and reviewed. If patient injury results from a failure to make use of available patient information, the physician may be held liable.
2. E-prescribing has been widely adopted and is currently used by more than 80 percent of office practices. Potential capabilities and benefits include:
 - Electronic prescriptions are transmitted via a network, such as Surescripts (which has data on more than 70 percent of patients), to all chain pharmacies and most independent and insurance formularies.
 - EHRs have an e-prescribing module, which provides electronic routing to pharmacies, quick access to drug formulary and eligibility information, and the patient's prescription history.
 - Most e-prescribing programs check for drug interactions, dosage errors, medication allergies, and patient-specific medication factors.
 - Office prescription renewal requests can be synchronized with most e-prescribing systems. Costs are lowered by flagging generic and "on-formulary" drugs.
 - While e-prescribing encourages patients to fill prescriptions, 28 percent of EHR prescriptions are not filled and 10-15 percent contain errors (one-third of which are potentially harmful).

However, practices are exposed to community medication histories through e-prescribing. For example, Dr. A renews a medication, and his e-prescribing program sends an alert advising him that the medication could interact with another drug the patient is taking. He has not prescribed that drug,

so his office staff will have to contact the patient to identify who has prescribed it, and then Dr. A will have to contact Dr. X to "negotiate" which drug will be discontinued or changed. If failure to take action results in patient injury from a drug interaction, Dr. A may be liable.

3. Drug-drug interaction lists generate frequent, annoying, and disruptive alerts, and doctors often develop "alert fatigue." It is estimated that two-thirds of alerts are overridden or disabled. If it can be shown that following a disabled alert would have prevented an adverse patient event (this will be documented in the metadata), the physician may be found liable for failing to follow it.
4. Doctors often copy information from a prior note or from the history and physical (H&P) and paste it into a new note or H&P, hopefully making changes where appropriate. This may work for the past medical history but is risky for progress notes and the physical examination, both of which may change. This also results in irrelevant over-documentation, and important new clinical information may be obscured. Copying and pasting may also perpetuate incorrect or outdated information that may compromise patient care. By substituting a word processor for the physician's thoughtful review and analysis, the narrative documentation of daily events and the patient's progress may be lost, thereby compromising the record of the patient's course. The quality of notes and documentation may be further compromised by the use of templates.
5. The computer may become a barrier between the doctor and the patient. When the doctor fills in a computer template, it may divert attention from the patient, limit interactive conversation, and restrict creative thinking. This may depersonalize and weaken the doctor-patient relationship. The computer's location in the office is an important ergonomic consideration; i.e., the location of electrical outlets shouldn't force you to sit with your back to the patient.
6. Many EHRs autopopulate fields in the H&P (from data derived from data fields in a prior H&P) and in procedure notes (from personalized or packaged templates). While over-documentation may facilitate billing, it may also generate an inappropriate number of billing codes, and entering erroneous or outdated clinical information may increase liability. For example, an internist was deposed and his EHR was the medical record. Some of the autopopulated fields contained obviously wrong information. At deposition, the plaintiff's attorney asked these questions:
 - a. "So is the information in this record accurate or not?"

RISK MANAGEMENT TIP

- b. “Do you bother looking at your records?”
 - c. “If these ‘autopopulated’ fields are incorrect, can we trust anything in this record?”
 - d. “Do you deliver the same level of care as you do in record keeping?”
7. EHRs are certified for compliance with Meaningful Use requirements, e.g., computerized provider order entry (CPOE), e-prescribing, Clinical Decision Support (CDS), and patient connectivity through Patient Portals. Physicians are encouraged to provide patients with clinically relevant, disease-specific educational and drug safety materials through these portals. However, providers are responsible for their content, which creates risk. Some EHRs have patient questionnaires that use an algorithm to interview the patient through these portals. The questionnaires may address, and memorialize in the record, issues that physicians are not prepared to pursue (depression, substance abuse, sexually transmitted disease, etc.). Lack of or incomplete follow-up can create potential liability - and provide a clear record for the plaintiff’s attorney to follow.
 8. Most vendor contracts attempt to shift liability resulting from faulty software design or CDS data onto the physician. Some malpractice policies may exclude coverage for product liability and indemnification of third parties. Read all contracts carefully.
 9. Electronic discovery: Plaintiff attorneys generally request printed copies of the EHR as well as copies in native format, which shows how the data was used (were CDS prompts and drug alerts followed or overridden?). They will also request the metadata, which includes logon and logoff times, what was reviewed and for how long, what changes or additions were made, and when the changes were made. Smartphone and e-mail records are also discoverable. It is important to remember that all physician interactions with the EHR are time-tracked and discoverable.
 10. Templates with drop-down menus facilitate data entry. However, drop-down menus are usually integrated with other automated features. An entry error (accidentally selecting the medication above or below the one desired on the menu) may be perpetuated elsewhere in the HER - and it may be overlooked, resulting in a new potential for error. Erroneous information, once entered into the EHR, is easily perpetuated and disseminated.
 11. EHRs provide e-prescribing drug information and CDS databases. Clinicians should know the source of the medication and CDS information in their EHRs, because it may be in conflict with the clinical standards of care or practice guidelines for their specialty and with the information in U.S. Food and Drug Administration (FDA) - approved drug labels or drug alerts.
 12. Computer-assisted documentation uses point-and-click lists, drop-down menus, autofill, templates, and canned text to bypass natural language and produce structured progress notes. These contain redundant, formulaic information, making it easy to overlook significant clinical information that is lost in a sea of normal or irrelevant findings. Communication with on-call and consulting physicians may be compromised, and abnormal lab and imaging test results may be missed.
- CDS provides alerts, warnings, and reminders for medication and chronic disease management and preventive care, but physicians may have to justify departures from these guidelines (documented in the EHR’s native format) if an adverse event occurs. Always document why a prompt was overridden. 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 in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

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 in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

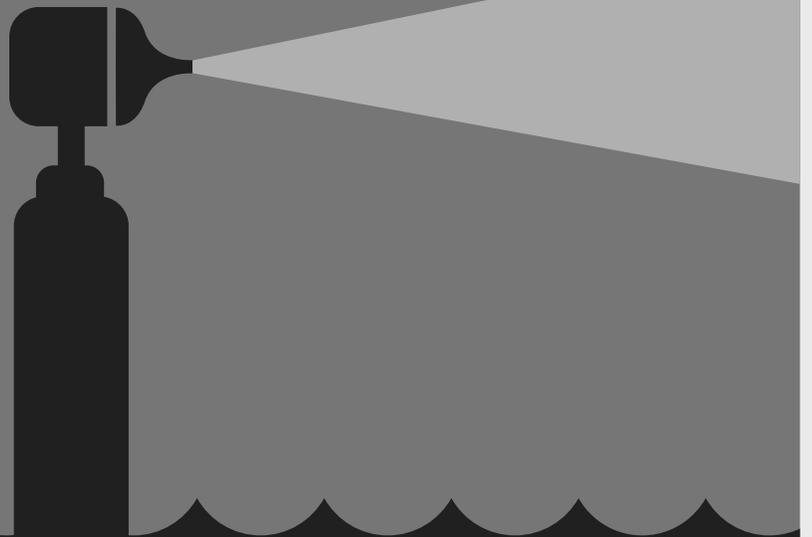
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FINAL MEDICARE (MACRA) RULE ISSUED

The Centers for Medicare and Medicaid Services (CMS) issued a final rule implementing the Medicare Access and CHIP Reauthorization Act (MACRA). While the AMA is in the process of fully analyzing the regulations, a first review reveals that CMS responded to many of the concerns expressed by physicians about the proposed rule issued last spring. For example:

- Details are provided about the 2017 transition period announced in September. The only physicians who will experience payment penalties in 2019 are those who choose to report no performance data next year, and those who report for at least 90-days will be eligible for positive payment adjustments.
- The low-volume threshold that exempts physicians from all performance reporting has been increased from \$10,000 in annual Medicare revenue and less than 100 Medicare patients to \$30,000 in revenue or 100 patients. CMS estimates that this change will exempt 32.5 percent of physicians and other clinicians from the program.
- Performance reporting requirements have been further reduced, and the resource use component of the Merit-based Incentive Payment System (MIPS) has been reweighted to zero for 2017.

Summaries, fact sheets and other CMS resources are available on the agency's web site. In the coming days, the AMA will make additional resources available on its own MACRA web page, which can be accessed at www.ama-assn.org/go/medicarepayment.

NEW TOOL FOR RECOGNIZING PHYSICIAN DISTRESS, PREVENTING SUICIDE

By: AMA staff writer Tim Smith

Physicians die by their own hands at much higher rates than do members of the general public, 40 percent higher in males and 130 percent higher in females, so recognizing and responding to physician distress is crucial. Physicians themselves are uniquely positioned to do this for their colleagues, but many are uncomfortable intervening and unsure what steps to take if they do get involved. A new resource offers guidance in successfully identifying distressed colleagues and helping them get the care they need.

Risk factors for physicians may be similar to those for the general public, but many physicians feel their identities are closely tied to their professional images, and this makes them more vulnerable to distress when problems arise at work.

Almost every state in the nation has a physician health program (PHP), and the Federation of State Physician Health Programs (www.fsphp.org/state-programs) maintains a listing of state PHPs with a description of the services provided by each. State PHPs may even be able to assist physicians in identifying others with experience and expertise in treating distressed physicians.

Still, physicians are often reluctant to access care.

Care for your colleagues, care for yourself

If you believe a physician colleague is displaying signs of distress, how should you approach her or him? How can you teach your care team to recognize physicians in distress or at risk for suicide? What actions can you take to support them?

Preventing Physician Distress and Suicide (www.stepsforward.org/modules/preventing-physician-suicide), a new module from the AMA's STEPS Forward™



collection of practice improvement strategies, focuses on the unique vulnerability and treatment needs of physicians.

It includes four steps to identifying at-risk physicians and referring them to appropriate care:

- 1. Talk about the risk factors and warning signs for suicide.** Risk factors can range from relationship problems to being named a defendant in a lawsuit. Warning signs can be as obvious as mood changes and increased alcohol use.
- 2. Take steps to standardize care-seeking in your organization.** One easy step is encouraging colleagues to take time off for vacation and sick leave.
- 3. Make it easy to find help.** For starters, be sure to post referral lists for resources inside and outside your organization in a highly visible location that does not require a password, and assure users that there is no tracing of page visits or downloads.
- 4. Consider creating a support system for physicians in your organization.** This can include simply reducing a physician's patient caseload and offering regular screenings for depression.

The module also features sample scenarios, scripting for approaching distressed physicians, a self-assessment for medical malpractice stress syndrome, a list of suicide prevention resources and other downloadable tools.

And don't forget: Self-care is one of the most visible ways to standardize care-seeking in your practice. Allow yourself time to recharge, talk about your own stress, say "no" when you need to and learn to recognize the signs of distress in yourself.



There are seven new modules now available from the AMA's STEPS Forward collection, bringing the total number of practice improvement strategies to 42, thanks to a grant from and collaboration with the Transforming Clinical Practices Initiative.

Editor's Note: The Michigan Health Professional Recovery Program can be reached at (800) 453-3784, email hprp@hprp.org, or visit their website at www.hprp.org.

HARNESSING SENIOR PHYSICIANS' EXPERTISE

By: contributing writer Tanya Albert Henry

Older physicians, especially those who are still interested in actively contributing to health care after retirement, have invaluable knowledge to pass on. Find out what one physician has to say about the profession finding new ways for these doctors to impart what they've learned.

Creating new opportunities

Late-career physicians need pathways that let them pursue professional mentoring, teaching and meaningful community involvement, such as volunteering or working with service agencies or communities that are important to their organizations, a Mayo Clinic Proceedings commentary urges.

Older physicians are less likely to be motivated by financial considerations and more likely to be looking for other rewards. Consequently, alternatives beyond cutting back their hours could help them "rediscover meaning and purpose in medicine and potentially prolong careers," writes commentary author William M. Spinelli, MD, a researcher at Allina Health's Division of Applied Research in Minnesota. "In return for this engagement, organizations would reap the benefit of the accumulated institutional wisdom and increased community engagement from senior clinicians as they continue medical practice and bridge the interval before the arrival of new primary care practitioners," he said.

A different way of thinking: From early exits to new roles

Long work hours, productivity demands and professional fatigue are driving a number of physicians out of practice earlier than they expected. Adding to the stress for some physicians is a growing number hospitals and practices requiring older physicians complete evaluations to see if they are still competent to practice.

A 2014 Physicians Foundation study found that 44 percent of physicians surveyed planned to make changes that would ultimately reduce patient access to their services, including cutting back on the number of patients seen, retiring or working part time.

Those statistics come at a time when primary care is facing a projected physician shortage. For years, fewer medical graduates have been choosing to go into primary care specialties such as family and internal medicine. At the same time, the U.S. population is living longer, resulting in more people needing care.

"A great deal of the health care system is focused on innovative practices and such things as work flow processes and payment reform," Dr. Spinelli said in a video accompanying his commentary. "I would suggest that another form of innovation is investing in the people who are responsible in helping with both patient care and implementation of these other new health care system design strategies."

Dr. Spinelli suggests that medicine can learn something from heartwood trees. As the trees age, the older cells at the core of the tree harden when they lose some of their ability to conduct water. As they harden, they perform the essential function of structurally supporting the tree.

"Specifically, the question at hand is, 'How can we leverage the knowledge, wisdom and experience of senior physicians at a time in their career when they are struggling with the pace, demands and changes in health care?'" Dr. Spinelli said.

He suggests that physicians can explore their commitment and passion for medicine and their communities by asking:

- How did I get to this stage of my career?
- What do I want the next stage of my career to look like?
- What are the skills needed and the possibilities available for this next stage?
- How can I learn from and share these journeys with colleagues?

Tackling senior physicians' concerns

The AMA earlier this year convened a national group of stakeholders to explore the growing trend of assessing the competency of aging physicians. The group, which included nearly three dozen representatives from organizations such as the Joint Commission and the Council of Medical Specialty Societies, was a recommendation of a recent report from the AMA Council on Medical Education.

The AMA Senior Physicians Section, which stands more than 55,000 members strong, was the driving force behind the AMA policy that led to the council report and the convening of the stakeholder group.

The AMA does not have a policy on whether physicians should be assessed, and the group began deliberation around key issues and challenges for determining whether national guidelines for assessment should be developed. Considerations include the legal implications of screening physicians based on age and the uncertainty of how to interpret cognitive or motor function tests given to physicians.

THE PHYSICIAN OF THE FUTURE: MORE LIKE DA VINCI

By: AMA staff writer Tim Smith

Which skills and qualities should typify the physician of the future? Answering this question is crucial for medical schools, especially given the many forces acting on medical education, including health care funding, the impact of technology and evolving patient users. According to one expert, the answer is clear but also complex: The physician of the future will



all levels, she noted, foremost with patients, but it will gain its fullest expression out in the community in the pursuit of the social determinants of health. It is the mechanism that will enable physicians to go upstream of not only many patients' health problems but also some of physicians' own health problems, such as burnout.

need to be a little bit of everything.

Meg Gaines, JD, LLM, is a distinguished clinical professor of law at the University of Wisconsin-Madison. She is also a co-founder of The Center for Patient Partnerships (www.patientpartnerships.org), which trains students from the schools of Law, Medicine, Nursing, Pharmacy and Social Work to provide advocacy to cancer patients and conducts research on issues relevant to patient care and health care delivery from the patient perspective.

At a recent meeting of the AMA's Accelerating Change in Medical Education Consortium in Chicago, she described the physician of the future from her perspective as an interprofessional team member.

"Patients will need their doctors to be advocates," Gaines said.

And partnering, she explained, will be the key to fulfilling that role.

"[It's] the vital 21st century skill," she said. "For practicing professionals, I think we need to be even more Leonardo da Vinci than we have been before, crossing the professional boundaries, being a little bit lawyers, a little bit doctors, a little bit nurses, a little bit social workers."

Collaboration is already required at

Overcoming barriers to change

Getting there, Gaines thinks, will require change not just in medical education but also in what physicians consider their scope of work.

"[One] of the barriers is the guild mentality in all professions, including medicine," she said. We have ego stuff - it's true in law too. We own some things, and we don't like it when the Internet allows you to [do them] without us. So we really do have to be ready to let go of some things."

One of the things Gaines says physicians will have to let go of is what she calls "the rescue fantasy."

"[It's] this notion that we're putting all this time and energy into this gestalt that's about saving people's lives, when really we do relatively little of that - maybe if we're trauma surgeons [we do] more of it - but mostly what we do is empower people to save their own lives. And that's what we have to teach."

That means building curricula for how to build capacity in others, she explained.

"Do the math," she said. "There aren't ever going to be enough of you to take care of all of us. So you have to have us taking care of ourselves. I want every primary care doctor to have a sign up in their office

that says, 'You are your own primary care provider 99.9 percent of the time. How can I help you?'"

Gaines noted her own involvement as a primary investigator for healthexperiencesusa.org, the US arm of the University of Oxford's healthtalk.org, which recently published its first module, on young adults' experiences with depression. The module is not a collection of anecdotes; it is a qualitatively and quantitatively researched sampling of experiences that people from across the US have had. It's an example, Gaines noted, of using technology to teach and not having to have people in the room with a patient.

On the edge of a new education frontier

Another core element of a new curriculum, Gaines said, will be self-care and well-being, and this will require medical schools to embrace human fallibility.

"[Professional curricula is] big on teaching striving for excellence and [not] on teaching what happens when you say, 'Uh oh, wish I'd done that differently.'" Gaines said. "I think it comes from being afraid that if we let down our façade of striving for excellence, [our students] will be ordinary, and we just have to let go of that. We need to help them figure out what happens at the 'Uh oh' moment and how they can stay alive and even well and get past it and help each other."

Gaines thinks such a shift will have some discomfiting implications for medical schools, but the discomfort will be temporary because physicians embrace change.

"[Students] do what they see us do, not what we tell them," she said. "So we need to co-create curriculum with patients, families and communities. We have to walk our talk. There's no way around it. And our first reaction - trust me, I have it - is, 'Yikes! How do we do that?!' This is a new frontier."

UPCOMING EVENTS

NOVEMBER 9 Free MSMS Webinar, “The Importance of Medical Documentation”, 12:15 pm - 1pm. There is no cost but registration is required, to register visit www.msms.org/eo .

NOVEMBER 12 MSMS 20th Annual Conference on Bioethics, 9 am - 4:30 pm at the Sheraton Hotel, Ann Arbor. For more information or to register visit www.msms.org/Education or call 517-336-7581.

NOVEMBER 12 “Scope of Pain: Safe and Competent Opioid Prescribing Education”, Beaumont Health System, 3711 W. 13 Mile Road in Royal Oak, 8 am - 12:30 pm. For more information or to register visit www.msms.org/eo or call 248-858-4670.

DECEMBER 6 MCMS Annual Meeting, Wyndham Garden Sterling Heights, 6:30 pm cocktails, 7 pm dinner and program.

DECEMBER 7 Free MSMS Webinar, “Human Trafficking Part 2: What to Look for in Patients”, 12:15 pm - 1pm. There is no cost but registration is required, to register visit www.msms.org/eo .

DECEMBER 8 MSMS conference “Practical Guidance for Health Care Compliance”, MSMS Headquarters in East Lansing, 10 am - 3 pm. For more information or to register visit www.msms.org/eo or call 517-336-7581.

DECEMBER 8 MSMS conference “Complete Coding Updates for 2017”, 1 pm - 4 pm, at the Sheraton Detroit Hotel in Novi. For more information or to register visit www.msms.org/eo or call 517-336-7581.

DECEMBER 9 MSMS conference “Care Management”, MSMS Headquarters in East Lansing, 9 am - 12 pm. For more information or to register visit www.msms.org/eo or call 517-336-7581

MAY 6-7, 2017 MSMS House of Delegates, Amway Grand Plaza in Grand Rapids.

ON-DEMAND WEBINARS MSMS has a catalog of on-demand webinars available, allowing you to watch and learn at your convenience. Check out the available series on HIT Legalities and Practicalities, Physician Executive Development and Choosing Wisely. Visit www.msms.org/eo

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

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New Members



ANGELA D. STOIAN, DO

Pediatrics - Board Certified

Medical School: Arizona College of Osteopathic Medicine of Midwestern University, 2004. Post Graduate Education: Sparrow Hospital, completed 2007. Hospital Affiliation: Beaumont. Currently

practicing at Shelby Pediatric Assoc. & Child Lung Center, 15125 22 Mile Road, Shelby Township, MI 48315, Ph. 586-532-0599, Fx. 586-566-8967.

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Fx. 586-416-0800, Website www.stclairortho.com



MARK A. BERGIN, MD

Orthopaedic Surgery - Board Certified & Sports Medicine

Medical School: Wayne State University, 2006. Post Graduate Education: Northwestern University, 2007; Rutgers University/University of Chicago, 2012;

University of Pittsburgh, 2013. Hospital Affiliation: Henry Ford Macomb, Beaumont Grosse Pointe, Beaumont Troy, St. John Medical Center.



KIRK GREGORY CLELAND, MD

Orthopaedic Surgery - Board Certified & Hand Surgery

Medical School: Wayne State University, 2008. Post Graduate Education: Henry Ford Hospital, Indiana University, University of Pittsburgh Medical Center Hamot. Hospital Affiliation: Henry Ford Macomb,

Beaumont Grosse Pointe, Beaumont Troy, St. John Medical Center.



JAMES J. DIETZ, MD

Orthopaedic Surgery - Board Certified & Hand Surgery

Medical School: Wayne State University, 1992. Post Graduate Education: Henry Ford Hospital, 1997; Hand Center of Western New York, 1998. Hospital Affiliation: Henry Ford Macomb, Beaumont Grosse

Pointe, St. John Medical Center.



CHRISTOPHER L. LEE, MD

Orthopaedic Surgery - Board Certified

Medical School: Wayne State University, 1972. Post Graduate Education: Wayne State University, 1976; Stanford University, 1977. Hospital Affiliation: St. John Hospital, Henry Ford Macomb, Beaumont

Grosse Pointe.



GLENN J. MINSTER, MD

Orthopaedic Surgery - Board Certified & Spine Surgery

Medical School: Wayne State University, 1990. Post Graduate Education: Wayne State University, 1995; Tulane Medical Center, 1996. Hospital Affiliation:

Henry Ford Macomb, Beaumont Grosse Pointe, St. John Medical Center.



RICHARD T. PERRY, MD

Orthopaedic Surgery - Board Certified & Hip and Knee Replacement

Medical School: University of Michigan, 1990. Post Graduate Education: Washington University, 1995.

Hospital Affiliation: St. John Hospital, Beaumont

Grosse Pointe, Henry Ford Macomb.



NICHOLAS J. SCHOCH, DO

Orthopaedic Surgery - Board Certified & Shoulder/ Knee Reconstruction

Medical School: Michigan State University, 1994.

Post Graduate Education: Mt. Clemens General,

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MATTHEW J. SCHRAMSKI, DO

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Medical School: Michigan State University, 2005.

Post Graduate Education: Michigan State University,

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Affiliation: Henry Ford Macomb, Beaumont Grosse

Pointe, Beaumont Troy, St. John Medical Center.



KANWALDEEP S. SIDHU, MD

Orthopaedic Surgery - Board Certified & Spine Surgery

Medical School: Wayne State University, 1989.

Post Graduate Education: University of Michigan,

1994; Beaumont Hospital, 1995. Hospital

Affiliation: St. John Hospital, Henry Ford

Macomb, Beaumont Grosse Pointe, McLaren Macomb.



CHRISTOPHER N. ZINGAS, MD

Orthopaedic Surgery - Board Certified & Foot & Ankle Reconstruction

Medical School: Wayne State University, 1989.

Post Graduate Education: Henry Ford Hospital,

1994; Baylor University (TX), 1995. Hospital

Affiliation: Henry Ford Macomb, Beaumont Grosse Pointe, St. John Medical Center.

Macomb County Medical Society Foundation

2016 Holiday Sharing Card Project

For this year's Holiday Sharing Card Project we are giving you the option of contributing to either or both of the following two local charities. We know that you receive several donation requests, but we hope that you will help those in need in your community. The MCMS Foundation is a 501(c)(3) non-profit charitable organization, as it pays for all costs associated with this project, **your donation is 100% tax deductible**. The MCMS Foundation's Tax ID number is 38-3180176.



Macomb County Food Program serves people in need of food through its 52 pantry distribution sites. Last year, they were able to provide nearly 2.9 million meals to feed hungry families, children, the elderly and disabled throughout Macomb County. 100% of every dollar donated is used to purchase food. The Food Program is able to purchase reduced cost food so for every dollar received the program can purchase two days worth of food.



Turning Point Shelter assists victims/survivors of domestic violence, sexual assault, and homelessness. They provide a 24-hour crisis hotline, emergency shelter, Forensic Nurse Examiner Program, legal advocacy, support groups and counseling services that help thousands of women and their children.

We will be sending cards to all MCMS members with a list inside of this year's Holiday Sharing Card participants. If you would like to have your name included as a donor, please complete the form below and return it along with your check to the MCMS Office no later than December 9, 2016.

If you have, any questions please contact the MCMS office at 810-387-0364 or Email mcms@msms.org.

✂ -----
Form and payment must be returned by December 9th

Name(s) to appear on holiday card _____

Address _____

Phone _____

Email _____



\$ _____
 Contribution to Food Program



\$ _____
 Contribution to Turning Point

Please make checks payable to: MCMS Foundation
Return form to: MCMS Foundation, P.O. Box 62, Yale, MI 48097-0062

The MCMS Foundation is a 501(c)(3) non-profit charitable organization sponsored by the Macomb County Medical Society. As the MCMS Foundation pays for all costs associated with this project, **your donation is 100% tax deductible**. The MCMS Foundation Tax ID # 38-3180176.

HEALTH CARE DELIVERY *Tools & Resources*

Legal and Regulatory

Health care law has become increasingly complex and physicians need to be better prepared than ever to address legal and regulatory constraints that impact medical practice. MSMS currently offers the following tools to member physicians:

Legal Services

General legal questions on a variety of issues of concern to physicians statewide (e.g., medical record retention, medical records charges, privacy issues, Stark, etc.) are answered for FREE as a benefit of MSMS membership. MSMS member physicians may access MSMS Legal Counsel by contacting the MSMS Health Care Delivery Department at 517/336-5723 or via email at cwheeler@msms.org.

Special Legal Services

MSMS members in need of a thorough legal review and consultation pertaining to overpayment audits, bylaws, and contracts are able to receive this benefit for a fixed fee. MSMS member physicians can contact the MSMS Health Care Delivery Department at 517/336-5723 or via email at cwheeler@msms.org for referral to the following services:

- Employment Contract Review Service | msms.org/contractreview
- Physician Audit Consultation Service | msms.org/auditconsult
- Medical Staff Bylaws Review Service | msms.org/bylawsreview
- HIT/EHR Vendor Contracting Review Service | msms.org/hitvendorreview

Legal Checklists

MSMS checklists provide physicians with a starting point to evaluate key areas that should be addressed in contracts, employee documents, and compliance plans.

- Managed Care Contracting | msms.org/managedcare
- Employed Physician Contracting | msms.org/employed
- Compliance Program | msms.org/compliance
- Employee Manual | msms.org/employeemanual
- HIT/EHR Vendor Contracting | msms.org/hitvendor

Legal Alerts and Guides

MSMS legal alerts and guides provide a succinct legal analysis of both timely and long-standing issues that impact the practice of medicine. These resources provide members with an informative, on-demand tool to answer questions regarding regulations, processes, etc. to ensure compliance. Many of the alerts are based on trending inquiries directly from physicians and their staff. Access our most popular documents below and more at www.msms.org/legal.

1. Medical Records Guide | msms.org/mrg
2. HIPAA Guide | msms.org/hipaaguide
3. Terminating a Physician/Patient Relationship | msms.org/tppr
4. Physician Medical Practice and Patient Financial Hardship Policy | msms.org/financialhardship
5. Patient Portals: What Physicians Need to Know | msms.org/patientportals
6. Health Plan Audits: What Every Physician Should Know | msms.org/healthplanaudits
7. What Physicians Need to Know When Patients File for Bankruptcy | msms.org/patientbankruptcy
8. Legal Requirements for Treating Hearing Impaired & Patients with Limited English Proficiency | msms.org/patientcommunications
9. Medical Treatment Decisions and Access to Medical Records by Parents of Minor Children | msms.org/custody
10. Mandatory Flu Shot for Employees: Policy Implementation & Best Practices | msms.org/mandatoryflushot

For more information about MSMS Health Care Delivery Tools & Resources, contact Carrie Wheeler at 517/336-5723 or cwheeler@msms.org. Also, visit www.msms.org/hcd.



	2016	2015	2014
AMEBIASIS.....	1	0	1
BLASTOMYCOSIS.....	0	0	1
BOTULISM (FOODBORNE).....	0	0	0
BOTULISM (INFECTIOUS).....	0	0	0
BRUCELLOSIS.....	0	0	0
CAMPYLOBACTER.....	79	78**	86**
CHICKENPOX.....	25**	32**	88**
CHLAMYDIA.....	2,183	2,735	2,468
COCCIDIOIDOMYCOSIS.....	1	2	7
CREUTZFELDT JAKOB.....	1**	1**	2**
CRYPTOCOCCOSIS.....	1	1	2
CRYPTOSPORIDIOSIS.....	7**	1	9**
DENGUE FEVER.....	1	1	0
DIPHTHERIA.....	0	0	0
EHRlichIOSIS.....	3**	0	1**
ENCEPHALITIS PRIMARY.....	1	2	2
ENC POST OTHER.....	1	1	2
FLU-LIKE DISEASE.....	16,406	27,943	28,824
GIARDIASIS.....	12	17	21
GONORRHEA.....	557	514	474
GRANULOMA INGUINALE.....	0	0	0
GUILLAIN-BARRE SYNDROME.....	9**	4**	6**
HEMOLYTIC UREMIC SYN.....	0	0	0
HEPATITIS A.....	6	5	4
HEPATITIS B (ACUTE).....	6	6	7
HEPATITIS B (CHRONIC).....	86**	132**	141**
HEPATITIS C (ACUTE).....	27**	16**	15
HEPATITIS C (CHRONIC).....	715**	688**	705**
HEPATITIS D.....	0	0	0
HEPATITIS E.....	0	0	0
H. FLU INVASIVE DISEASE.....	11	11	9
HISTOPLASMOSIS.....	2**	5**	2**
HIV ^.....	55	76	54
INFLUENZA.....	1,195	764	820**
KAWASAKI SYNDROME.....	3	10	6
LEGIONNAIRE'S DISEASE.....	16	24	24
LISTERIOSIS.....	0	1	1

	2016	2015	2014
LYME DISEASE.....	3	7	1
MALARIA.....	2	2	1
MEASLES.....	0	0	0
MENINGITIS VIRAL.....	31**	60**	44**
MENINGITIS BACTERIAL/BACTEREMIA (EXCLUDING N. MENINGITIDIS).....	8	10	8
MENINGOCOCCAL DISEASE.....	1	1	1
MUMPS.....	2**	0	2**
PERTUSSIS.....	25**	35**	83**
POLIO.....	0	0	0
PSITTACOSIS.....	0	0	0
Q FEVER.....	0	0	0
RABIES ANIMAL.....	0	1	3
RABIES HUMAN.....	0	0	0
REYE SYNDROME.....	0	0	0
ROCKY MNTN SPOTTED FVR.....	0	0	0
RUBELLA.....	0	0	0
SALMONELLOSIS.....	55	82	75**
SHIGELLOSIS.....	27	21	9
STEC***.....	4	8	11
STREP DIS, INV, GRP A.....	23	27	26
STREP PNEUMO, INV + DR.....	48	52	45
SYPHILIS.....	38	104	77
SYPHILIS CONGENITAL.....	0	1	0
TETANUS.....	0	0	0
TOXIC SHOCK SYNDROME.....	0	0	1
TUBERCULOSIS.....	8	6	11
TULAREMIA.....	0	0	0
TYPHOID FEVER.....	0	1	1
VIBRIOSIS.....	1	0	0
VISA.....	0	0	1
WEST NILE VIRUS.....	2	4**	0**
YELLOW FEVER.....	0	0	0
ZIKA.....	4	0	0

**INCLUDES BOTH PROBABLE & CONFIRMED CASE REPORTS

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

^ Previously reported as "AIDS"

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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!

Application Code:

State and County Medical Society MEMBERSHIP APPLICATION

Join MSMS and your County Medical Society online at www.joinmsms.org

- | | |
|--|---|
| <input type="radio"/> I am in my first year of practice post-residency. | <input type="radio"/> I work 20 hours or less per week. |
| <input type="radio"/> I am in my second year of practice post-residency. | <input type="radio"/> I am currently in active military duty. |
| <input type="radio"/> I am in my third year of practice post-residency. | <input type="radio"/> I am in full, active practice. |
| <input type="radio"/> I have moved into Michigan; this is my first year practicing in the state. | <input type="radio"/> I am a resident/fellow. |

Male Female

First (legal) Name: _____ Middle Name: _____ Last Name: _____ MD DO

Nickname or Preferred Form of Legal Name: _____ Maiden Name (if applicable) _____

Job Title: _____

W Phone _____ W Fax _____ H Phone _____ H Fax _____

Mobile: _____ Email Address _____

Office Address Preferred Mail Preferred Bill Preferred Mail and Bill

City: _____ State: _____ Zip: _____

Home Address Preferred Mail Preferred Bill Preferred Mail and Bill

City: _____ State: _____ Zip: _____

*Please base my county medical society membership on the county of my (if addresses are in different counties): Office Address Home Address

*Birth Date: ____/____/____ Birth Country _____ MI Medical License #: _____ ME #: _____

Medical School _____ Graduation Year: _____ ECFMG # (if applicable) _____

Residency Program _____ Program Completion Year _____

Fellowship Program _____ Program Completion Year _____

Hospital Affiliation _____

• Primary Specialty _____ Board Certified: Yes No

• Secondary Specialty _____ Board Certified: Yes No

Marital Status: Single Married Divorced Spouse's First Name: _____ Spouse's Last Name: _____

Is your spouse a physician?: Yes No If yes, are they a member of MSMS?: Yes No

Within the last five years, have you been convicted of a felony crime?: Yes No If "yes," please provide full information: _____

Within the last five years, have you been the subject of any disciplinary action by any medical society or hospital staff?: Yes No

If "yes," please provide full information: _____

I agree to support the County Medical Society Constitution and Bylaws, the Michigan State Medical Society Constitution and Bylaws, and the Principles of Ethics of the American Medical Association as applied by the AMA and the MSMS Judicial Commission.

Signature _____ Date: _____

County Medical Society Use Only
Reviewed and Approved by: