Macomb

Medicus

Journal of the Macomb County Medical Society

September/
October
2020
Issue
Vol. 28
No. 4

Macomb County Medical Society
P.O. Box 551
Lexington, Michigan 48450-0551

Macomb Medicus

Journal of the Macomb County Medical Society

Toll Free 877-264-6592

e-mail macombcms@gmail.com

web www.macombcms.org

IN THIS ISSUE

September/October 2020
Vol. 28, No. 4

Human Resources Tip....3
MSMS Update....4
Hospital News....7
What Your Patients Must Know About Rx Shopping Online....11
Membership Report....12
Upcoming Events....12
AMA News....13
MIOSHA Launches New Site for COVID-19 Workplace Safety....19
Macomb County Legislator Contact Guide....Back Cover

Macomb Medicus is published bimonthly: Sept./Oct., Nov./Dec., Jan./Feb., March/April, and May/June by the Macomb County Medical Society. Subscription to Macomb Medicus is included in the annual society membership dues. Adrian Christie, MD, takes photographs unless otherwise indicated.

Address changes and all communications relative to articles and advertising in Macomb Medicus should be addressed to: Editor, Macomb County Medical Society, P.O. Box 551, Lexington, MI 48450-0551.

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

Back to School Plans Create Homework for Employers

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

AS SCHOOLS RETURN FOR THE FALL, COVID-19 CONTINUES TO CREATE CHALLENGES FOR EMPLOYEES AND EMPLOYERS ALIKE. Many districts have moved their curriculum to a virtual setting, while others are offering hybrid models. Even in-person classes are no guarantee that an employee will be able to work as scheduled. All it takes is one outbreak and in-person classes will be suspended unexpectedly. It is inevitable that employees will need assistance juggling the increased demands on their time.

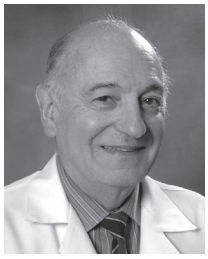
The federally funded Families First Coronavirus Response Act (FFCRA) provides employees with paid time off offered by the Emergency Paid Sick Leave Act (EPSLA) and Expanded Family Medical Leave Act (EFMLA) which could be used to supplement time away from work due to childcare issues resulting from COVID-19-related school or daycare closures. However, these hours are only available if the employer has less than 500 employees AND the employer has not exempted themselves from offering FFCRA leave. This last part is significant to physicians because under the current FFCRA legislation and subsequent Department of Labor guidance, health care employers can choose to exempt themselves from FFCRA compliance. Which means, employees with school-aged children may find themselves without a safety net to assist with wage continuation or job protection outside of existing employer benefit programs like PTO, vacation and/or sick banks.

This has caused health care employers to weigh the pros and cons of FFCRA leave very carefully. The labor pool is not very deep right now given increased unemployment compensation and peoples' general anxiety around COVID-19 exposure in the workplace. Current staff who feel forced to choose between work and their children's education due to inflexible leave programs will not be easily replaced. For that reason, employers are well-advised to assist with resources that can aid employees in their decision-making process. To begin, survey your staff to learn what the current needs are so you can predict potential impact to work schedules and staffing needs. If you have multiple team members that are struggling with childcare/school closures, it is time to get creative. FFCRA is one solution, but consider assembling a list of alternative options available in your community and using this to facilitate discussion among affected team members. Employees can share their plans with others who are in a similar situation and employers can provide additional ideas that may be of interest, ie: Facebook groups for schools in the area where learning pods are being formed, summer camps that are retooling their offerings to provide a place for online learning, names of tutors and/or licensed teachers in the area who are willing to assist with in-home learning, employer-funded childcare subsidies to offset increased financial burdens or employer contracted arrangements with a childcare/learning center that would offer discounted rates to employees in need.

"The labor pool is not very deep right now given increased unemployment compensation and peoples' general anxiety around COVID-19 exposure in the workplace."

These are just a few of the many solutions parents and employers are considering to minimize the disruption that COVID is likely to cause in the workplace this fall. While it is not typical for an employer to be so involved in employee childcare decisions, these are times are anything but typical. Practices who do their homework to offer flexibility and choice will weather this storm much better than those who draw a hard line and place the burden of nontraditional school arrangements solely on the shoulders of their staff. Choose wisely. The effort employers put in now will pay dividends when it's time to overcome the next COVID-19 hurdle in the workplace.

HEALTH INSURER'S FAILURE TO REMOVE BARRIERS TO CARE AND STREAMLINE PRIOR AUTHORIZATION REQUIRES LEGISLATIVE ACTION ADDRESSING BURDENS



By: Adrian J. Christie, MD
MSMS Region 2
District Director

New survey finds potentially harmful consequences of prior authorization process imposed by health insurers on necessary care

Earlier this year, hundreds of Michigan patients, their advocates, and their physicians packed multiple legislative committee hearings to share their experiences with insurance company prior authorization regulations. New survey data released by the American Medical Association (AMA) bolsters what they testified to lawmakers -burdensome prior authorization red tape is adversely affecting patient outcomes.

According to the survey, 91% of physicians say prior authorization leads to delays in care and 16% report the delay in care has led to a patient's hospitalization. Despite a commitment by insurers two years ago to streamline prior authorization for patients, America's physicians and their staff report in this poll that they still spend an average of two business days each week completing prior authorization forms and requirements and 86% of those surveyed say that the burden is increasing.

Prior authorization has long prevented patients from receiving the care they need from their physicians - causing treatment delays of days and weeks, or sometimes even months. In fact, 24% of the AMA's survey respondents reported that a prior authorization has led to an adverse event for one of their patients. Moreover, today, as the nation faces the COVID-19 pandemic, prior authorization continues to interfere with access to care by forcing patients to make multiple trips to the pharmacy, delaying transfers out of hospital settings, and pulling valuable practice resources away from patient care when they need it most.

"Our patients are suffering because insurers, even during a pandemic, are choosing profits over patient care. This must stop," said AMA President Susan R. Bailey, MD "Because insurers will not change their ways despite their rhetoric, policymakers have an important opportunity to rein in prior authorization requirements that adversely affect patient health."

The AMA and Michigan State Medical Society (MSMS) are urging federal lawmakers to pass H.R. 3107. The bipartisan legislation would improve care delivery for America's seniors by requiring Medicare Advantage plans abide by many of the concepts outlined in the consensus statement, such as streamlining and standardizing prior authorization and improving transparency of health insurer programs. A bipartisan group of 234 members of the U.S. House of Representatives have co-sponsored the bill, including five members of Michigan's congressional delegation. The AMA and MSMS appreciate the support of U.S. Representatives Jack Bergman, Daniel T. Kildee, Haley Stevens, Fred Upton and Tim Walberg.

Meanwhile, MSMS, as part of the Health Can't Wait Coalition, has been working on the state-level to streamline prior authorization and protect patients from unnecessary barriers to care. Most recently MSMS supported S.B. 612, which would introduce new transparency and clinical validity requirements to ensure patients have access to care.

"MSMS and the AMA call on Michigan lawmakers to take action in the coming legislative session on behalf of patients and enact S.B. 612. Now is the time to make sure that insurers are not standing in the way of patients' access to covered services, deterring patients from seeking care, or intruding the patient-physicians relationship." stated Bobby Mukkamala, MD, MSMS president and chair-elect of the AMA Board of Trustees.

To learn more about the Health Can't Wait coalition and to join the fight to rein in harmful prior authorization programs, visit healthcantwait.org.

WHAT TO EXPECT FROM GOVERNOR WHITMER'S IMPLICIT BIAS TRAINING DIRECTIVE

As part of her response to the COVID-19 pandemic and the disproportionate impact the virus has on people of color, Governor Whitmer issued Executive Directive 2020-7, requiring health professionals to take implicit bias training.

Thus far, COVID-19 is more than four times more prevalent among black patients than among white patients. The hope is this disparity can be reduced through training designed to address unconscious bias by medical professionals.

As dictated by the directive, the Michigan Department of Legal and Regulatory Affairs (LARA) is required to consult with relevant stakeholders - including the Michigan State Medical Society - by November 1, 2020 to help determine relevant goals and concerns under the new rule. Through this process, MSMS will advocate for a flexible curriculum that allows any continuing medical education (CME) provider - such as local hospitals - to provide the required programming.

It will be at least a year before any new rules are officially

promulgated, and even longer before any required training is developed and offered. In years past, any new mandated continuing medical education has had at least a three-year roll out.

Despite that long horizon, there are CME opportunities on racial inequality and implicit bias in the near term that our members can take advantage of, including:

- A Tele-Town Hall for Physicians with Jason Adam Wasserman, PhD, available online now titled, "Race Inequalities and COVID-19: Contagion, Severity, and Social Systems"A virtual session during the Fall update on COVID-19, scheduled for September 16-17
- A virtual session during the Bioethics conference, scheduled for November 14

All of these CME opportunities were scheduled before Governor Whitmer issued her directive, and we encourage physicians and providers to participate in any these trainings. However, please note that they may not count toward any relicensure requirements, which will likely be dictated by official start associated with this new training requirement that has yet to be determined.

MANDATORY ELECTRONIC PRESCRIBING OF ALL PRESCRIPTIONS UPDATE

Governor Whitmer recently signed into law legislation (Public Acts 134, 135, and 136 of 2020) to require prescribers to electronically transmit all prescriptions, including those for controlled substances, to the patient's chosen pharmacy beginning October 1, 2021. Various exceptions including a waiver process is included in the final version.

Despite opposition from MSMS, the Michigan Academy of Family Physicians, the Michigan Psychiatric Society, and Michigan College of Emergency Physicians, the Legislature was intent on joining the federal government (SUPPORT Act- includes an electronic prescribing mandate for controlled substances under Medicare) and at least 22 other states in mandating some form of electronic prescribing. MSMS was able to obtain some improvements to the bills; however, we were not successful in removing the unfunded mandate or penalty provisions.

Below are some tips for prescribers interested in starting the electronic prescription of controlled substances (EPCS).

Prescribers using an electronic health record (EHR), should check with their EHR vendor to determine which compliance pathway they must follow (depends on whether the system is registered to an individual DEA number or to an institutional or shared DEA number) and whether the EHR software version their practice is using is certified and approved for EPCS. If not, an updated version will be necessary before proceeding. If it is certified and approved, the following three steps need to be completed before a prescriber is legally able to EPCS:

1. Complete identity proofing in order to obtain an authorization and authorization credential.
2. Set-up two-factor authentication. This is how the application verifies the person using the application is someone who has been given access.
3. Set software access. At each location where an EPCS application will be used for controlled substances, at least two individuals must be designated to manage access to the application. At least one must be a DEA registrant (a DEA authorized prescriber). These two individuals will set secure access controls for the electronic prescribing application software.

Surescripts has some easy to follow video tutorials on their website to help walk you through the basic steps toward EPCS.

Prescribers without an EHR also have options. If you are currently using an electronic prescribing application for non-controlled medications, check with the vendor to see if they have a certified EPCS upgrade. If you are not using electronic prescribing at all, stand-alone electronic prescribing systems with EPCS are available

that don't require an EHR. There are systems designed to meet a variety of needs, from those that offer simplicity and basic functionality and can be used on a smart phone or tablet (e.g., Dr. First iPrescribe) to those that will offer a fuller range of functionality (e.g., Dr. First EPCS Gold). When you make your EPCS selection, steps 1-3 outlined above for EHR users must be completed in order to send electronic prescriptions for controlled substances.

Whether you are adding EPCS to your EHR, are upgrading your stand-alone eRx system, or are just wading into electronic prescribing, getting started now is extremely important. This will not only ensure you are able to have a smooth transition, keep interruptions to patient care at a minimum, but also allow you to have a secure way to prescribe controlled substances.

If you have further questions regarding electronic prescribing, please contact Dara J. Barrera at 517-336-5770.

FREE MSMS ON-DEMAND WEBINARS

MSMS is offering members the following on-demand webinars for free. To access them go to their website at https://www.msms.org/Education.

COVID-19: CARES Act Impact
CME Credits: 0.50

COVID-19: Telemedicine and Other Technology Codes in a COVID-19: Environment
CME Credits: 0.75

COVID-19: What Physicians Need to Know as Employers During the COVID-19 Pandemic
CME Credits: 1.00

Health Care Provider's Role in Screening and Counseling for Interpersonal and Domestic Violence: Dilemmas and Opportunities
CME Credits: 0.50

MSMS WEBSITE TO GET PPE FOR PHYSICIAN PRACTICES

The Michigan State Medical Society, in partnership with Foresight Group, launched a website, http://MSMS.org/PPESupplies, to get personal protective equipment and other supplies for Michigan's physician practices. The website allows physicians and their practices to purchase essential medical supplies, including respirators, face shields, goggles, and gowns.

Once the practice identifies their need and quantity, information is shared with Foresight Group, who will then identify the best rate and delivery times available, confirm need with the practice, collect payment information, and place the order, which will then ship directly to the practice.

If there are specific supplies needed, please notify MSMS@MSMS.org so those supplies may be added as an option.

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.

McLaren Macomb Hospital

MCLAREN MACOMB FIRST IN THE COUNTY TO PERFORM WEB PROCEDURE FOR COMPLEX ANEURYSM

McLaren Macomb, is the first in the county to use Woven EndoBridge (WEB) Aneurysm Embolization System for the treatment of a complex intracranial aneurysm. Performed by interventional neurologist Dr. Aniel Majjhoo, the procedure is a minimally invasive alternative treatment to potentially life-threatening brain aneurysms.

An aneurysm is a thinning and weakening of the arterial wall, creating a balloon-like bulge. Depending on its size or location within the brain, aneurysms may be classified as 'complex,' potentially making traditional treatments less effective.

The WEB implant is a permanent nickel titanium mesh ball that self-expands, reducing blood flow to the site of the aneurysm.

"We have had great success in treating patients with this new system," Dr. Majjhoo said. "This innovative technology allows us to treat several various complex aneurysms both electively and emergently, providing more treatment options for a wide variety of patients. Because it is such a minimally invasive system, the patient is at less risk for complications, has a shorter hospital stay, and a faster recovery time."

Performed by interventional neurologists utilizing the latest imaging technology, once the implant is tunneled by the catheter system to the aneurysm in the brain, it is detached from the delivery system and placed within the aneurysm, reducing blood flow that aids in its growth while also promoting clotting.

Blood flow aids in the growth of the aneurysm, which increases the chances of rupture, sending blood into the brain and skull. A ruptured aneurysm causes a subarachnoid hemorrhage, a severely life-threatening condition. Treatments are aimed at diverting blood flow from the aneurysm, stopping its growth and, in some treatments, naturally shrinking it.

Un-ruptured aneurysms may not present with any symptoms while others will have symptoms of worsening headaches numbness on one side of the face, double vision and drooping eyelids. Ruptured aneurysm symptoms (requiring emergency medical care) include a sudden-onset severe headache described as the 'worst headache ever,' nausea and vomiting, stiff neck, blurred and double vision, seizure, sensitivity to light, droopy eyelids, confusion and loss of consciousness.

Learn more about neurological care at McLaren Macomb at www.mclaren.org/macombneurology.

MCLAREN MACOMB TO OPEN THE WAYNE AND JOAN WEBBER EMERGENCY AND TRAUMA CENTER

After just over two years of construction, McLaren Macomb, opened the Wayne and Joan Webber Emergency and Trauma Center on June 15.

The project, resulting in a new six-story tower with the emergency department occupying the ground level, first broke ground in April 2018 and has vastly changed the face of McLaren Macomb's Mount Clemens campus.

"Tracking the health needs of Macomb County, it was clear to us that the demand for emergency care was high and would continue to grow," said Tom Brisse, McLaren Macomb President and CEO. "McLaren Macomb is proud to now be in the position to meet that need and provide accessible emergency care to anyone who seeks it."

More than doubling the size of the hospital's existing emergency department, the new ED features 68 treatment spaces and a capacity to treat approximately 120,000 patients per year.

And as Macomb County's busiest trauma center, the department's seven resuscitation rooms are an increase from the three existing trauma bays.

The department features separate rooms for pediatric patients, and rooms designed to address the specific needs of geriatric and behavioral health patients. The increased size allows for larger waiting areas, with spaces designated for higher- and lower-acuity patients and pediatric patients.

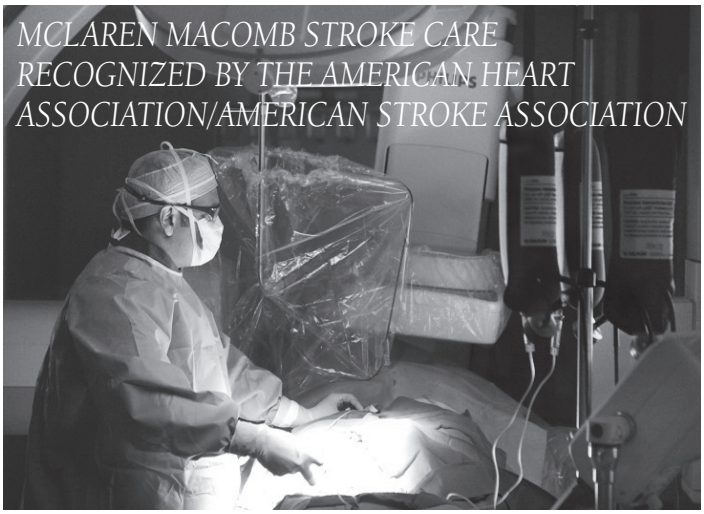
"The entire department was designed with the care of the patient in mind," said Dr. James Larkin, physician and director of emergency medicine at McLaren Macomb. "This benefits us as physicians as well because it allows us to treat more patients in a timelier manner."

With the emergency department occupying the main floor of the new Northwest Tower, the lower level features a first-class learning, training and recreation center for the hospital's more than 100 resident and fellow physicians.

Remaining floors have been left open for future constructions, with current plans of adding surgical suites on the second floor.

To learn more about the services offered at McLaren Macomb, including emergency and trauma care, visit www.mclaren.org/macomb.

MCLAREN MACOMB STROKE CARE RECOGNIZED BY THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION



McLaren Macomb, part of the statewide McLaren Stroke Network, has earned recognition from the American Heart Association/American Stroke Association for its proficient and effective care of stroke patients. The organization recognized the hospital with its Get With The Guidelines® Stroke Gold Plus designation, an advanced quality recognition that acknowledges the hospital's consistent compliance with national quality measurements.

Additionally, McLaren Macomb earned the organization's Target: Stroke Honor Roll recognition for its timeliness in administering IV tPA, a medication to dissolve stroke-causing blood clots, and Target: Type 2 Diabetes Honor Roll, which recognizes the program for providing the latest evidence-based care to diabetic stroke patients.

"We are fortunate to have the expertise and knowledge of many skilled clinical professionals, which directly results in a higher level of care for our patients and best possible outcomes," said Dr. Aniel Majjhoo, an interventional neurologist and medical director of the McLaren Macomb Neurosciences Institute. "Adhering to the established guidelines puts our patients and providers in a position for success, and ultimately more treated patients being safely discharged home."

Recognitions are based on the most up-to-date, evidence-based treatment guidelines set by the AHA/ASA to improve the care and clinical outcomes of stroke patients. Gold Plus level is earned by complying with those guidelines and meeting those quality measurements for a period of 12 consecutive months.

AHA/ASA guidelines include making a timely diagnosis, administering appropriate medications and providing stroke patients with discharge instructions that address their stroke risk factors.

This achievement demonstrates a continued high level of care for stroke patients at McLaren Macomb, as the program earned the Gold Plus distinction last year as well.

Part of the McLaren Stroke Network, McLaren Macomb has routinely earned national recognition for its care, treatment, quality and outcomes. The most experienced stroke program in Macomb County, McLaren Macomb was the first program in Macomb County capable of performing interventional thrombectomy procedures, the standard of care set by the AHA/ASA's guidelines.

Stroke is the fifth leading cause of death and the leading cause of adult disability in the United States. McLaren Macomb's unique program approach allows for 24/7 initial evaluations by an interventional neurologist for all suspected stroke patients and 24/7 neuro intensive care coverage.

To learn more about the stroke program at McLaren Macomb, visit www.mclaren.org/macombstroke.

MCLAREN MACOMB RECOGNIZED BY HEALTHGRADES WITH PATIENT SAFETY EXCELLENCE AWARD

McLaren Macomb, was awarded for its safe care environment by Healthgrades, which recognized the hospital by including it on their list of Patient Safety Excellence Award 2020 recipients. Released annually, Healthgrades' Patient Safety Excellence Award recognizes hospitals "that have the lowest occurrences of 14 preventable patient safety events."

Inclusion on the list places McLaren Macomb among the top 10 percent of acute care hospitals nationwide in patient safety.

"This is a time when patients have to feel unquestionably safe while they're in the hospital, and that they are in the care of skilled and diligent clinical professionals," said Dr. Beth Wendt, medical director of quality and patient safety officer at McLaren Macomb. "Earning this recognition is assurance to our bedside care teams that their processes are the best practices and directly impact the well-being of the patient. It's a recognition acknowledging their dedication, and one shared with the entire staff."

Hospital data is tracked and measured, determining that provider's effectiveness in preventing injuries, infections and other serious conditions while patients are in their care. Healthgrades considers 14 patient safety indicators and other measurements to create the list of recipients.

McLaren Macomb is one of five McLaren Health Care providers to earn the recognition, with McLaren Oakland, McLaren Port Huron, McLaren Lapeer Region and McLaren Greater Lansing also included on the list.

To learn more about how McLaren Macomb is providing safe care during COVID-19, visit www.mclaren.org/safecare.

Henry Ford Macomb Hospital

EXPANDING CARDIAC PROCEDURES AT HENRY FORD MACOMB

The cardiac team at Henry Ford Macomb performed the hospital's first successful WATCHMAN Implant on July 7. WATCHMAN is an exciting addition to the hospital's ever-growing array of advanced cardiovascular services. This one-time, minimally invasive procedure provides non-valvular atrial fibrillation (NVAF) patients with the potential of a lifetime of stroke risk reduction without the bleeding risk associated with long-term oral anticoagulant therapy. Doctors make a small cut in the upper leg and guide WATCHMAN through a catheter into the left atrial appendage. The procedure is done under general anesthesia and typically takes about an hour. Patients stay overnight and are discharged the next day.

August also marked the one-year anniversary of the hospital's TAVR (transcatheter aortic valve replacement) program. This minimally invasive procedure allows doctors to replace a defective heart valve without open-heart surgery.

HENRY FORD MACOMB STROKE PROGRAM WINS ELITE QUALITY AWARDS

The American Heart Association/American Stroke Association has again awarded Henry Ford Macomb Hospital the Get with the Guidelines Stroke Gold Plus and Target Stroke Honor Roll Elite achievement awards. These quality awards recognize the hospital's commitment to ensuring stroke patients receive the most effective treatment according to nationally recognized, research-based guidelines.

Ascension Macomb-Oakland Hospital

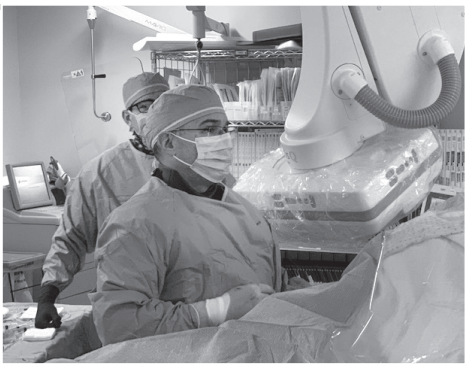
ASCENSION SE MICHIGAN HOSPITALS EARN HIGH MARKS FROM U.S. NEWS & WORLD REPORT

Several Ascension SE Michigan hospitals have been recognized in the latest U.S. News & World Report hospital rankings. The news outlet annually reviews hospitals' performance in adult and pediatric clinical specialties, procedures and conditions. Scores are based on several factors, including survival, patient safety, nurse staffing and more. Hospitals are ranked nationally in specialties from cancer to urology and rated in common procedures and conditions, such as heart bypass surgery, hip and knee replacement and COPD. Hospitals are also ranked regionally within states and major metro areas. The following Ascension SE Michigan hospitals were recognized this year:

- Ascension Providence Hospital, Southfield: 7th in Michigan, 5th in Detroit metro; high performing in eight procedures and conditions
- Ascension St. John Hospital: 17th in Michigan; high performing in four procedures and conditions
- Ascension Macomb-Oakland Hospital: high performing in two procedures and conditions
- Ascension Providence Rochester Hospital: high performing in 2 procedures and conditions

ASCENSION ST. JOHN HOSPITAL SURGEON AMONG FIRST IN STATE TO PERFORM WAVELINQ™ PROCEDURE

In late February, David Lorelli, MD, vascular surgeon, was the first Ascension Michigan physician to use the WavelinQ™ 4F EndoAVF System to create an endovascular arteriovenous fistula (endoAVF) for hemodialysis access in patients who have chronic kidney disease and need dialysis. This minimally invasive procedure uses two thin, flexible magnetic catheters which are inserted in adjacent blood vessels in the arm under X-ray guidance - one into the ulnar artery and one into an ulnar or radial vein. The magnets attract as the catheters are advanced. Once aligned a small burst of radiofrequency energy is used to create a channel between the ulnar artery and ulnar vein to create the endovascular fistula, after which the catheters are removed. Dr. Lorelli uses ultrasound to evaluate dialysis patients for this procedure and says WavelinQ™ offers several benefits over traditional open surgery.



"It's an outpatient procedure that takes 1-2 hours, there is no significant recovery or down-time, a reduced risk of scarring or arm disfigurement, and because of the two access points, an increased likelihood that patients will get a usable AV fistula," explained Dr. Lorelli.

ASCENSION ST. JOHN'S EMERGENCY DEPARTMENT HONORED WITH LANTERN AWARD FOR EXCELLENCE IN PRACTICE AND PERFORMANCE

The Emergency Nurses Association recognized Ascension St. John Hospital's Emergency Department with its Lantern Award. Among the 25 Lantern award recipients this year, Ascension St. John was the only Michigan hospital and the only Ascension hospital in the U.S. to be recognized.

Since 2011, this national award has recognized emergency departments that demonstrate excellent practice and innovative performance through leadership, education, advocacy and research. Ascension St. John Hospital leadership says the award is recognition of the ED's success which is built on teamwork and connection with their stakeholders.

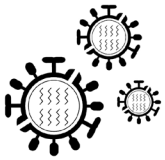
"Some of the positive changes within our department has been our increased work on suicide patient safety, guardianship patients, human trafficking education, medication errors with improvement opportunities, our ED RN residency program, and our EMS outreach," said Elizabeth Littlejohn, Interim Administrative Director, Emergency and CDU Services, Ascension Southeastern Michigan . "We have an amazing team in the Emergency Department, and we work very hard to give the best patient care, by striving to keep our patients at the center of our focus, each and every day."

Communicating the Benefits of Seasonal Influenza Vaccine during COVID-19

Influenza (flu) severity varies from year to year, but flu always brings serious consequences.[i] The prevention of influenza and its associated consequences is important every year. Although the effectiveness of the flu vaccine can vary, overall the vaccine markedly lowers the risk of influenza-related illness, hospitalization, and death.[ii]

The COVID-19 pandemic means preventing influenza during 2020–21 is more important than ever. Influenza and COVID-19 share many symptoms. Preventing influenza means fewer people will need to seek medical care and testing for possible COVID-19 or influenza. And increasing flu vaccination uptake saves healthcare resources for COVID-19 and other conditions. Begin recommending flu vaccine now, and vaccinate throughout the flu season, providing extra outreach to those at highest risk of severe COVID-19 or severe influenza.

CDC estimates that, from October 1, 2019–April 4, 2020, there were:

39 million–56 million flu **illnesses**	18 million–26 million flu **medical visits**	410,000–740,000 flu **hospitalizations**	24,000–62,000 flu **deaths**
			

SOURCE: CDC, 2020

What are the Benefits of Seasonal Flu Vaccine?

Research shows flu vaccination:

Reduces Hospitalization and Death

- ✔ Pediatric deaths from flu were cut in half for children with underlying high-risk medical conditions and by two-thirds for healthy children[iii]
- ✔ Influenza hospitalizations were cut in half for all adults (including those 65+ years of age)[iv]
- ✔ Influenza hospitalizations dropped dramatically among people with chronic health conditions – by 79% for people with diabetes[v] and 52% for those with chronic lung disease[vi]
- ✔ Vaccinating long-term care facility (LTCF) staff reduces hospitalizations and deaths in LTCF residents[vii]

Reduces Severity of Illness in Hospitalized Individuals

- ✔ Among adults hospitalized with flu, intensive care unit (ICU) admissions decreased by more than half (59%), and fewer days were spent in ICU if vaccinated[viii]
- ✔ Children's risk of admission to a pediatric intensive care unit (PICU) for flu-related illness was cut by almost 75%[ix]

Reduces Risks for Major Cardiac Events

- ✔ Risk of a major cardiac event (e.g., heart attack) among adults with existing cardiovascular disease was reduced by more than one-third[x]

Protects Pregnant Women and Their Babies

- ✔ For pregnant women, flu-associated acute respiratory infections were cut in half[xi], and flu-associated hospitalizations were reduced by 40%[xii]
- ✔ Influenza illnesses and influenza-related hospitalizations in infants under 6 months of age fell by half when their mothers were vaccinated[xiii,xiv]

Vaccination rates* remain well below optimal levels:

63% children 6 months–17 years
45% adults 18+ years
68% adults 65+ years
81% healthcare personnel
54% pregnant women

*Estimates from the 2018–19 influenza season.
Source: CDC *FluVaxView*

How to Discuss Vaccine Effectiveness Tips

- **Keep it simple: "Flu vaccine helps reduce risk of hospitalization and death."**
- **Use a presumptive approach: "Today we are giving you your annual flu vaccination."**
- **Communicate why we vaccinate: "Vaccination prevents flu and severe outcomes of flu." "Preventing the flu also means preventing missed work and helps you avoid doctor appointments and unnecessary medications. It also means preventing flu symptoms that can mimic COVID-19, saving healthcare resources needed for COVID-19 care."**
- **Communicate the variability and unpredictability of flu: "This is why it is best to get an annual flu vaccination."**
- **Acknowledge that flu vaccination is not always a perfect match with the circulating virus types. But flu and flu-related severe illnesses are common: outbreaks occur almost every year. "The vaccine is the best way to reduce your risk of flu and its negative outcomes."**

FOOTNOTES

i CDC. Estimated Influenza Illnesses, Medical visits, Hospitalizations, and Deaths in the United States – 2018–2019 Influenza Season. www.cdc.gov/flu/about/burden/2018-2019.html
ii CDC. CDC Seasonal Flu Vaccine Effectiveness Studies. www.cdc.gov/flu/vaccines-work/effectiveness-studies.htm
iii Flannery, 2017, *Pediatrics.* DOI: 10.1542/peds.2016-4244
iv Ferdinands, 2019, *Journal of Infectious Diseases.* DOI: 10.1093/infdis/jiy723
v Colquhoun, 1997, *Epidemiology & Infection.* DOI: 10.1017/S095026889700825X
vi Nichol, 1999, *Annals of Internal Medicine.* DOI: 10.7326/0003-4819-130-5-199903020-00003
vii E. Frentzel, 2020, *JAMDA*, DOI: 10.1016/j.jamda.2019.11.008
viii Thompson, 2018, *Vaccine.* DOI: 10.1016/j.vaccine.2018.07.028
ix Ferdinands, 2014, *Journal of Infectious Diseases.* DOI: 10.1093/infdis/jiu185
x Udell, 2013, *JAMA.* DOI: 10.1001/jama.2013.279206
xi Thompson, 2014, *Clinical Infectious Diseases.* DOI: 10.1093/cid/cit750
xii Thompson, 2019, *Clinical Infectious Diseases.* DOI: 10.1093/cid/ciy737
xiii Mølgaard-Nielsen, 2019, *Journal of Internal Medicine.* DOI: 10.1111/joim.12947
xiv Poehling, 2011, *American Journal of Obstetrics and Gynecology.* DOI: 10.1016/j.ajog.20111.02.042

AIM ASSOCIATION OF IMMUNIZATION MANAGERS

immunization action coalition IAC immunize.org

www.immunize.org/catg.d/p3115.pdf • Item #P3115 (7/20)

What your patients must know about Rx shopping online

By: Kevin B. O'Reilly, AMA News Editor

With millions of newly unemployed Americans facing the prospect of losing access to the prescription drugs they need, physicians are being urged to raise awareness with their patients about the dangers of shopping online for cheap medicines.

The National Association of Boards of Pharmacy (NABP) notes that 95% of websites that sell prescription-only medicine are doing so outside the law, without licenses to dispense medication in the U.S. They are dispensing medications that "are foreign, unapproved, substandard, and counterfeit," the NABP's Executive Director/Secretary Lemrey "Al" Carter, PharmD, MS, RPh, wrote in a recent letter to the AMA.

"Most consumers are unaware of these risks of buying medication from any of the tens of thousands of fake online pharmacies engaging in these practices. Substandard and counterfeit medications may contain too much, too little, or none of the active pharmaceutical ingredients the patient needs," Carter noted. "They may contain toxic fillers, contaminants, or may not have been stored as necessary to maintain efficacy."

Why it's important: Too often, patients will turn to online pharmacies for convenience or in an attempt to save money, "not realizing the risks these sites pose," the NABP says.

"So-called Canadian pharmacies shipping to consumers in the U.S. do so without the proper licenses. They source medications from outside the tightly regulated U.S. supply chain," the NABP's letter notes. Such sites often sell medications that lack approval from the U.S. Food and Drug Administration.

According to NABP, among other things a safe online pharmacy will:

- Be licensed in the country or jurisdiction in which they are located.
- Accept only therapeutically valid prescriptions.
- Comply with drug laws and professional practice laws.
- Comply with privacy laws and ensure patient confidentiality.
- Provide readily accessible contact information for patient care inquiries and provide timely responses.

Websites using the pharmacy domain have been verified as safe by the NABP.

Learn more: NABP operates the https://safe.pharmacy website. Patients and physicians using that site can enter any URL of any online pharmacy to find out whether it is safe or not recommended.

Find out more at the AMA's TruthInRx website (https://truthinrx.org) about why we need drug-price transparency now.

New Members

MATTHEW L. EDWARDS, DO

Internal Medicine - Board Certified & Cardiovascular Disease - Board Certified

Medical School: Pikeville College of Osteopathic Medicine (KY), 2012. Post Graduate Education: McLaren Oakland (Internal Medicine), completed in 2015; McLaren Oakland (Cardiology), completed in 2018; Ascension Macomb-Oakland (Interventional Cardiology), completed in 2019. Hospital Affiliations: Henry Ford Macomb, Ascension Macomb-Oakland, McLaren Macomb, Ascension St. John. Currently practicing at Cardiology Associates of MI, 50505 Schoenherr Rd., Ste. 320, Shelby Township, MI 48315, ph. 586-580-3062, fx. 586-580-3143, website www.cardofmich.com.

SHEEL Y. TOLIA, DO

Cardiology - Board Certified & Internal Medicine - Board Certified

Medical School: Michigan State University of College of Osteopathic Medicine, 2009. Post Graduate Education: Ascension Providence (Internal Medicine), completed in 2012; Ascension Providence (Cardiology), completed in 2015. Hospital Affiliations: Ascension Macomb-Oakland, Henry Ford Macomb, Ascension St. John. Currently practicing at Cardiology Associates of MI, 46591 Romeo Plank Rd., Building 2B, Macomb, MI 48044, ph. 586-580-3062, fx, 586-226-6001, website www.cardofmich.com.

UPCOMING EVENTS

OCTOBER 20 MSMS Virtual Conference "A Day of Board of Medicine Renewal Requirements", 9 am - 3:30 pm, 5 Category 1 CME Credits, cost $150 for MSMS Members. This conference will cover: Controlled Substance License Requirements, Pain and Symptom Management, Medical Ethics, and Human Trafficking. For more information or to register visit www.msms.org/eo

OCTOBER 21-23 MSMS Annual Scientific Meeting. This will be a Virtual Conference. For more information or to register visit www.msms.org/eo

OCTOBER 28-30 MSMS Annual Scientific Meeting. This will be a Virtual Conference. For more information or to register visit www.msms.org/eo

NOVEMBER 14 MSMS Annual Conference on Bioethics - Moral Courage and Medical Professionalism. For more information or to register visit www.msms.org/eo

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 by visiting https://connect.msms.org/Education-Events/On-Demand-Webinars

Some of the FREE On-Demand Webinars offered:

- COVID-19: AMA Advocacy and Physician Resources, .75 CME Credit
- COVID-19: Best Practices for Implementing Telemedicine, .75 CME Credit
- COVID-19: CARES Act Impact: Q&A with CPAs, .75 CME Credit
- COVID-19: Leading Through Crisis: Financial Guidance and Strategies
- COVID-19: New Employment Policies for Practices, .5 CME Credit
- COVID-19: New Waivers and Billing Changes for Telemedicine, 1 CME Credit
- Race Inequalities and COVID-19: Contagion, Severity, and Social Systems, .75 CME Credit
- COVID-19: Safe and Innovative Office Procedures for Seeing Patients, .75 CME Credit
- COVID-19: Telemedicine and Other Technology Codes in a COVID-19 Environment, .75 CME Credit
- COVID-19: Testing, Tracing and Tracking, .75 CME Credit
- COVID-19: The Changing Health Care Landscape - Preventing Diabetes During and Beyond the Pandemic, 1 CME Credit
- COVID-19: What Physicians Need to Know as Employers During the COVID-19 Pandemic, 1 CME Credit

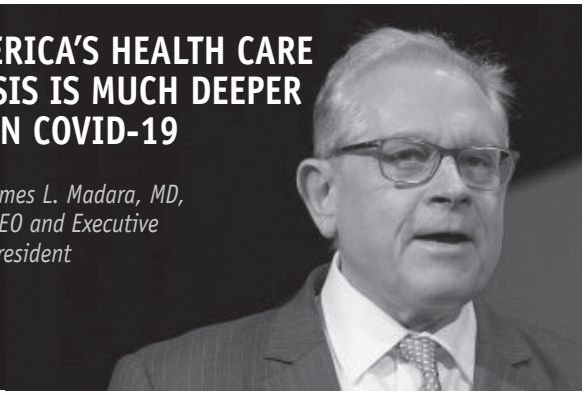
Watch for emails and fliers with the details of upcoming events.

Does the MCMS have your email address? If not, send it to us at macombcms@gmail.com so that we can keep you informed!

Change of Address? Let us know! Call 877-264-6592 or Email us macombcms@gmail.com any changes.

AMERICA'S HEALTH CARE CRISIS IS MUCH DEEPER THAN COVID-19

By: James L. Madara, MD, AMA CEO and Executive Vice President



The coronavirus pandemic presents a challenge unlike anything we've faced in this country for generations. But to be clear, COVID-19 didn't create the problems in our health system, it revealed them in a way that can no longer be ignored.

The U.S. health system that exists today is a hodgepodge of ideas, programs and regulations that is both extraordinarily expensive and highly inefficient. And despite its size and technological advancements, our health system is beset by tremendous gaps and inequities that favor some groups while unfairly disadvantaging others - minoritized communities, people living in rural areas, and people who are unable to afford or access health insurance, just to name a few.

As we have seen throughout this pandemic, these and other underlying factors result in some people being disproportionately affected by the dangers of COVID-19, just as it makes them more susceptible to the dangers of chronic conditions, such as hypertension and diabetes, that are by far the largest drain on our health system.

COVID-19 is a crisis because the threat to public health, our economy and our way of life is immediate. But eventually - thanks to the heroism of physicians, nurses and all frontline caregivers, public health officials, and the tireless work of scientists and researchers to develop a vaccine - this nightmare will come to an end. Whenever that day arrives, we'll be left with the realization that much about our health system is failing the very people it's supposed to serve - the public.

Put another way, the U.S. health system has pre-competitive needs that must be addressed regardless of the type of system we have in place a decade from now. Among them:

- Realigning our health system around the need to prevent and treat chronic disease, which affects some 100 million people in the U.S. and represents more than 80 cents out of every dollar spent on health care.
- Solving the dilemma of data liquidity so that information can more seamlessly be shared across systems.
- Training our physician workforce for the challenges of the 21st century, not the 20th.
- Eliminating needless paperwork and regulatory burdens that are obstacles to efficient, high-quality care.
- Working with purpose to root out racism inside the halls of medicine and to identify and eliminate systemic inequities that are most responsible for poorer health outcomes for Black and Brown communities.

These needs have existed long before the COVID-19 pandemic captured our attention and they will persist far into the future unless leaders in health care, business and technology work collaboratively to disrupt the status quo and chart a new course for our country's health system - a system that is affordable, efficient and accessible for everyone.

Over the next several months, I'll be publishing columns on LinkedIn to talk about the pain points of our health system in the COVID-19 era and talk about where we should be focusing our attention to fix our health system.

The American Medical Association has been a leading force to reform and improve our health system for 174 years, and our strategic priorities today reflect the realities of modern medicine and where it needs to go in the future. Our work is focused on removing the obstacles that interfere with patient care, driving the future of medicine by reinventing medical education and training, and improving the health of the nation by leading the charge to prevent chronic disease and emerging health crises.

The urgency of COVID-19 and the immense challenges that have come with it, tell us that we're on the right path. This pandemic offers a stark reminder of the persistent inequities in health care and in society that demand our attention and focus to solve. It reminds us that even the best-trained and most-experienced physicians need the right tools, equipment and support to deliver the very best care to patients. And it reminds us of the importance - and urgency - of prevention, whether its routine check-ins to treat high blood pressure or simply wearing a mask in a crowded supermarket.

This pandemic is a watershed moment in American history, one we must seize upon to fix the most glaring problems in our health system. We can't ignore one health crisis for the sake of another.

WANT TO DEFEAT COVID-19? YOU CAN DO YOUR PART WHEN YOU #MASKUP

By: Susan R. Bailey, MD, AMA President

Turning the tide against COVID-19 is a goal all of us can get behind - and you can do your part by getting behind a mask. It is absolutely time to #MaskUp.

As physicians, it is critical that we help our patients understand their risks for transmission through clear and simple communication firmly rooted in science. The AMA is partnering with other leading health organizations on #MaskUp to

encourage more people to minimize the spread of COVID-19 by wearing masks.

Physicians are guided by science and evidence. And in the case of SARS-CoV-2, the data is overwhelming that covering your nose and mouth - along with practicing physical distancing, washing your hands frequently, avoiding large gatherings and limiting time spent indoors with others - provides the best protection against further spread.

Putting it simply, wearing a mask saves lives.

Physicians who inform and educate patients on the need to #MaskUp are playing a vital role in this effort. A campaign toolkit and additional AMA resources to achieve this goal are available on the AMA website.

Physicians can lead the charge to reverse this trend by helping patients fully understand how COVID-19 transmission occurs, and the steps they can take to minimize their risk of infection, through clear and simple communication rooted in evidence-based science. This approach will dispel myths and replace misinformation while fostering a spirit of cooperation, reinforcing the steps we know will limit the spread of the virus. One of the most important steps is wearing a mask whenever we leave home.

Medical researchers are pressing the search for both a vaccine to prevent a SARS-CoV-2 infection and an effective treatment for those who contract it. Until those advances are achieved, we must remember that we are not powerless in responding to the most serious public health crisis in our lifetimes. Wearing a mask and following evidence-based public health interventions will reduce transmission of the virus and save lives.

I urge you to join this effort, and to join me, the broader health community, and people from across our nation as we all #MaskUp!

WHY DEPRESSION, ANXIETY ARE PREVALENT DURING COVID-19

By: Marc Zarefsky, Contributing AMA News Writer

Former First Lady Michelle Obama recently revealed that she is one of those people battling "low-grade depression," and she has lots of company. One in three Americans is dealing with symptoms of stress or anxiety, according to data from the U.S. Census Bureau and the National Center for Health Statistics.

Speaking on "The Michelle Obama Podcast," Mrs. Obama spoke about how COVID-19 and ongoing racial tensions across the country have affected her mental well-being.

The following day, AMA Immediate Past President Patrice Harris, MD, MA, commended the former First Lady for her candor.

"I thought it was important that Mrs. Obama talked about the fact that she's had difficult days and had some days where she feels like she had a low-grade depression," Dr. Harris said. "We're talking about it [mental health], and that's important."

Stigma has surrounded mental health for years, Dr. Harris said, particularly among African Americans and Latinx. Now, with increased stressors such as job loss and financial insecurity, as well as the physical distancing required to limit the spread of the coronavirus, the risk of depression and anxiety is even more prevalent. Having a recognizable figure such as Michelle Obama openly acknowledge her struggles is helpful to dispel stigma.

Dr. Harris spoke about this and other topics related to COVID-19 and mental health as part of the AMA's ongoing "Prioritizing Equity" video series with AMA Chief Health Equity Officer Aletha Maybank, MD, MPH, and Luz M. Garcini, PhD, MPH, assistant professor at the Center for Research to Advance Community Health at the University of Texas Health Science Center in San Antonio Long School of Medicine.

The mental health of health care providers

As the number of COVID-19 cases continues to rise across the country, physicians and other health professionals are becoming strained. Their mental health is of particular concern to Dr. Harris, who heard from countless physicians about their

COVID-19 experiences during her term as AMA president.

"We've been trained to take care of a [health] crisis, but the way we've been trained and the way we've thought about crises and disasters is that they would be time-limited; this public health crisis has been unrelenting and nonstop for many physicians," she said. "There's been no opportunity for any downtime."

Dr. Garcini said the ongoing stress facing physicians is particularly felt by doctors of color, and she said more diversity is needed across medicine. A 2018 report from the Association of American Medical Colleges found that only 5% of all active physicians were Black, and only 5.8% were Latinx.

Beyond the lack of diversity, physicians of all colors are put under added stress as they consider whether they have the appropriate tools or resources needed to best treat each patient they see, Dr. Garcini said.

Medicine is still working to figure out how to disseminate "contextually sensitive treatments for our providers to best meet the needs of our communities," she said. "That creates added tension and stress for health care workers."

What you can do to improve your mental health

As the novel coronavirus pandemic moves into its fifth month, it is more important than ever for people to examine their mental well-being and recognize when they may feel anxious, sad or depressed.

Dr. Harris implored the audience to get information from reputable sources. Misleading or inaccurate data can be a source of further anxiety, she noted. Additionally, she urged everyone not to fear reaching out for help when in need.

She and Dr. Garcini both spoke about the importance of trust - particularly in the field of mental health, where patients tell their doctors things they won't even share with their spouses or loved ones. Dr. Garcini said we all need to work on building trust between one another.

"There is a need to change the rhetoric that is taking place in our country," she said. "We need to build more tolerant environments, more empathetic communities and less divisiveness among our people. We need to equip our communities and empower them to disseminate valid and reliable sources of information that are ... contributing to so much fear among them."

WHY SO MANY PATIENTS STILL CAN'T CONNECT TO DOCTORS VIA TELEHEALTH

By: Andis Robeznieks, Senior AMA News Writer

Older adults are more likely to have chronic conditions, disabilities and severe complications from COVID-19, making equitable access to telehealth services essential. But many Medicare patients are unable to connect to the necessary technology or are unready to use it, according to two research letters published in JAMA Internal Medicine.

More than 41% of Medicare patients lack access to a desktop or laptop computer with a high-speed internet connection at home, almost 41% don't have a smartphone with a wireless data plan, and more than 26% didn't have access to either, according to the research from University of Pittsburgh and Harvard Medical School researchers.

The researchers analyzed responses to the 2018 American Community Survey from Medicare beneficiaries who were not living in nursing homes. They found that those less likely to have digital access were 85 or older, widowed, Black or Hispanic, enrolled in Medicaid, had a disability, or had a high school education or less.

"Our results underscore a need to address disparities in digital access among patients," their letter states. One solution they suggested was expanding a federal program that provides lower-cost telephone and internet access for low-income families to also provide help in obtaining devices needed for video visits.

Telehealth "unreadiness" and inequity

In the other letter, researchers from the geriatrics division at the University of California, San Francisco, found that up to 20% of older adults may be "unready" for telehealth visits.

The Centers for Medicare & Medicaid Services (CMS) helped when it made payment for audio-only visits equal to that of audio-visual communication and inpatient visits, but the UCSF researchers say "phone visits are suboptimal for care that requires visual assessment."

They analyzed responses from Medicare beneficiaries participating in the National Health and Aging Trends Study to calculate how many individuals were "unready" for telehealth because they:

- Had difficulty hearing well enough to use a telephone - even with hearing aids.
- Had problems speaking or making oneself understood.
- Had possible or probable dementia.
- Had difficulty seeing well enough to read a newspaper or watch television - even with glasses.
- Did not own an internet-enabled device or were unaware of how to use one.
- Did not use email, texting, or internet in the past month.

It adds up to 13 million older adults who may have difficulty connecting with telehealth services, including "a disproportionate number of those may be among the already disadvantaged," the researchers noted.

Indeed, un-readiness was more common in patients who were older, unmarried, men, Black or Hispanic, lived in rural areas, and who had less education, lower income and worse self-reported health.

Of patients 85 years and older, 72% met criteria for un-readiness.

"We are leaving behind a sizable number of older adults in this migration to telemedicine - and these are people living in homes, not facilities!" tweeted lead author Kenneth Lam, MD.

About 13,000 beneficiaries in fee-for-service Medicare were receiving telehealth services before the COVID-19 public health emergency. This number exploded to 1.7 million during the last week of this past April, according to "Early Impact of CMS Expansion of Medicare Telehealth During COVID-19," a Health Affairs report written by CMS Administrator Seema Verma.

In all, more than 9 million Medicare beneficiaries received telehealth service between mid-March and Mid-June, Verma wrote.

But, even with this success, more needs to be done to reach those that cannot or are unable to connect with their physicians via telehealth, the UCSF researchers say.

"Policies should recognize and bridge this digital divide," they wrote. "As telemedicine becomes ubiquitous, telecommunication devices should be covered as a medical necessity, especially given the correlation between poverty and telemedicine un-readiness."

They suggest that accommodations be made, such as closed captioning for those with hearing impairment, to make virtual visits more accessible.

"To build an accessible telemedicine system, we need actionable plans and contingencies to overcome the high prevalence of inexperience with technology and disability in the older population," Dr. Lam said in a UCSF news release. "This includes devices with better designed user interfaces to get connected, digital accommodations for hearing and visual impairments, services to train older adults in the use of devices and - for some clinicians - keeping their offices open during the pandemic."

NATION'S DRUG OVERDOSE EPIDEMIC REQUIRES NEW POLICY FOCUS

By: Andis Robeznieks, Senior AMANews Writer

The nation's focus is understandably set on the deadly COVID-19 pandemic, yet nearly 72,000 Americans died from an unintentional drug overdose last year. A new report from the AMA Opioid Task Force details actions physicians have taken, recognizes the evolving nature of the overdose epidemic, and identifies barriers that continue to stymie progress.

"Health insurance companies continue to delay and deny access to non-opioid pain care and evidence-based treatment for opioid-use disorder (OUD), while pharmacy chains, pharmacy benefit managers and state laws continue to inappropriately use arbitrary guidelines to restrict access to legitimate medication that some patients need to help manage their pain," the report states.

The AMA Opioid Task Force 2020 report highlights how, even as physicians write fewer prescriptions for opioid analgesics, the nation still faces an overdose epidemic that is increasingly fueled by illicitly manufactured fentanyl and fentanyl analogues, psychostimulants such as methamphetamine, heroin, cocaine and drug combinations.

"The nation needs to confront the fact that the nation's drug overdose epidemic is now being driven predominantly by highly potent illicit fentanyl, heroin, methamphetamine and cocaine, although mortality involving prescription opioids remains a top concern," said AMA Opioid Task Force Chair Patrice A. Harris, MD, MA, who also is the AMA's immediate past president.

Statistics show epidemic's evolution

The report provides grim statistics detailing how the epidemic evolved between 2015 and 2019.

According to the report, deaths involving:

- Illicitly manufactured fentanyl and fentanyl analogs jumped 510% from 5,766 to 35,171.
- Stimulants such as methamphetamine rose 258% from 4,402 to 15,770.
- Cocaine climbed 181% from 5,496 to 15,465.
- Heroin grew 30.5% from 10,788 to 14,080.

From a high of 15,003 deaths for a 12-month total ending in July 2017, deaths involving prescription opioids fell 21.4% to 11,797 at the end of 2019, according to the Centers for Disease Control and Prevention.

"If it wasn't for naloxone, there likely would be tens of thousands additional deaths," said Dr. Harris, who has chaired the AMA Opioid Task Force since its inception.

The report identifies these persistent barriers that block patients' access to evidence-based care:

Prior Authorization. Despite medical society and patient advocacy, only 21 states and the District of Columbia have enacted laws limiting public and private insurers from imposing prior authorization requirements on services or medication for substance-use disorders (SUDs). In

fact, the report cites a survey from the American Board of Pain Medicine that found 92% of pain medicine physicians said they have been required to submit a prior authorization for non-opioid pain care

Parity law noncompliance. Even fewer states have taken meaningful action to enforce mental health and SUD parity laws.

Barriers to comprehensive, multi-modal, multidisciplinary pain care and rehabilitation programs. Access to prescription opioid analgesics have decreased in every state, and none have taken meaningful action to require health insurers to increase access to non-opioid pain care or to remove arbitrary restrictions on access to opioid therapy.

Crisis framework

A major problem continues to be that efforts to end the epidemic have largely fallen into a reactionary "crisis framework" that results in the creation of ineffective one-size-fits-all strategies, especially with data collection.

Current overdose data collection is inconsistent across the nation; it is difficult to understand and fix what is not appropriately measured. Implementation of systems to track overdose and mortality trends is necessary in order to identify equitable public health interventions that include comprehensive, disaggregated, racial and ethnic data collection related to testing, hospitalization, and mortality associated with opioids and other substances.

"Going forward, physicians, public health officials, policymakers and health insurance companies must work together to create an integrated, sustainable, predictable and resilient public health system," the report states.

Dr. Harris agreed.

"It is far past time for policymakers, health insurers, pharmacy chains and pharmacy benefit managers to remove all barriers to evidence-based care for patients with pain and those with an SUD," she said.

During a recent episode of the "AMA COVID-19 Update" discussing the pandemic's impact on the overdose epidemic, Dr. Harris repeated her call for stakeholders to work together as the isolation and financial uncertainty created by the pandemic puts patients at risk for relapse.

"It is so important that we continue to work together to increase access to treatment for opioid-use disorder, that we increase access to naloxone and also harm-reduction programs such as syringe-exchange programs," she said, adding that AMA advocacy with the federal government has achieved results.

"The key issue here is eliminating treatment barriers, and one thing that has been allowed is the increase of take-home medicine of methadone," Dr. Harris said.

The AMA has encouraged physicians to consider co-prescribing naloxone when prescribing opioids to ensure patients have ready access to the lifesaving medication. Just recently, the U.S. Food and Drug Administration ordered that labeling for opioid medications include a recommendation that health care professionals discuss naloxone and consider prescribing it to patients with an increased risk of overdose.

Dr. Harris described the requirement "as a starting point for discussion between patients and physicians."

"The AMA has encouraged physicians to prescribe naloxone to patients at risk of overdose as part of a proactive and coordinated public health approach to opioid-related overdoses," she said. "With overdoses increasing, the more harm-reduction strategies we can employ, and the increased access patients have to naloxone, the better."

PHYSICIANS: ANTIBIOTIC RESISTANCE IS A PROBLEM, BUT NOT IN MY OFFICE

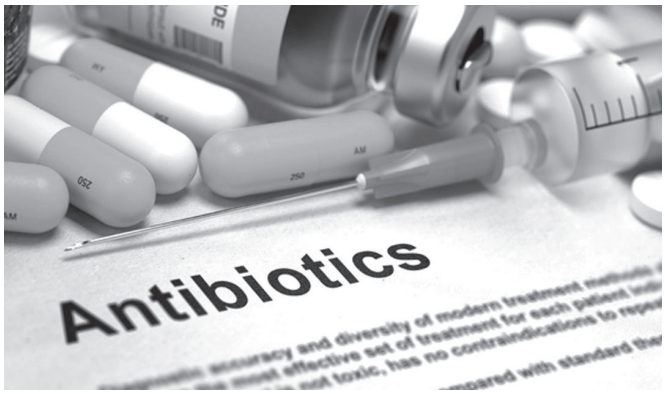
By: Sara Berg, Senior AMA News Writer

Public health advocates are studying ways to reduce unnecessary prescriptions in order to avoid the acceleration of antibiotic resistance. This comes at a time when there are high levels of antibiotic use among COVID-19 patients, underscoring the need to establish stewardship programs. However, while 94% of primary care physicians agree antibiotic resistance is a problem in the U.S., 55% don't see it as an issue in their own practice, according to recent research.

Before the COVID-19 pandemic, the AMA and The Pew Charitable Trusts conducted focus groups with physicians in Chicago, Los Angeles, Philadelphia, and Birmingham, Alabama and a national survey of 1,550 primary care physicians in the U.S. Results were weighted by geographic region and medical specialty to mirror actual distribution of U.S. physicians using the AMA's Physician Masterfile.

Published in the peer-reviewed journal BMJ Open, the journal article "Primary

care physicians' attitudes and perceptions towards antibiotic resistance and outpatient antibiotic stewardship in the USA: a qualitative study," highlights the findings of the focus groups, which assessed perceptions about antibiotic resistance to better understand the barriers to effective stewardship.



Results from the survey found that 91% of physicians felt that inappropriate prescribing was a problem in outpatient settings while only 37% felt it was an issue in their practice. Additionally, while 91% of respondents felt that antibiotic stewardship was appropriate office-based practices, they still ranked resistance as less important than other public health issues. Almost half also felt they would need a lot of help to implement stewardship, but were likely to implement efforts in response to feedback or incentives from payers or health departments.

From the eight focus groups from four major U.S. cities emerged several common themes that illustrated the attitudes of physicians about antibiotic resistance.

It is less important than other public health issues

Physicians maintained the perception that antibiotic resistance was less important in their medical practice when compared to other public health issues commonly faced, such as obesity, type 2 diabetes and opioid misuse.

Additionally, "while many participants acknowledged that antibiotic resistance is a concern, many did not see it as an issue that impacted their patients or their daily practice," said the study. "Instead, most participants considered antibiotic resistance as something affecting sicker, hospitalized patients."

However, some physicians did acknowledge an increase in resistant infections in patients with urinary tract or skin infections. Yet, they still classified antibiotic resistance as an issue affecting inpatient medicine.

Prescriptions are driven by other doctors, patient demand

"Participants indicated that they believed inappropriate outpatient antibiotic prescribing is largely driven by clinicians other than themselves, namely those practicing in urgent care offices and retail clinics," said the study. "This contributed to the feeling that resisting patient demand for antibiotics is futile, as patients can simply see another clinician and get what they want."

Another common theme revolved around pressure from patients who expect antibiotics even when not medically indicated. This was a recurring theme that was revisited many times throughout the focus groups. However, some physicians - mostly pediatricians - indicated that if they had a long-standing relationship with a patient, they would be more likely to push back against prescribing an antibiotic.

Patient and physician education are key

Focus group discussions looked at antibiotic stewardship efforts and participants displayed strong support for patient and physician education.

"Consistent with the perception of patient demand for antibiotics generating concern, participants emphasized that, in order for them to be able to effectively do their jobs, their patients need to be educated about when antibiotics are and are not appropriate and why judicious antibiotic use is critical to combating antibiotic resistance," said the study.

Some educational options include written materials in different languages, videos for waiting rooms and direct-to-consumer advertisements. This education should be provided prior to a patient visit.

Additionally, many participants also indicated that physician education was important for outpatient antibiotic stewardship. Educational efforts were more helpful than other interventions, such as feedback on prescribing practices. However, physicians disagreed on whether education should be mandatory or voluntary.

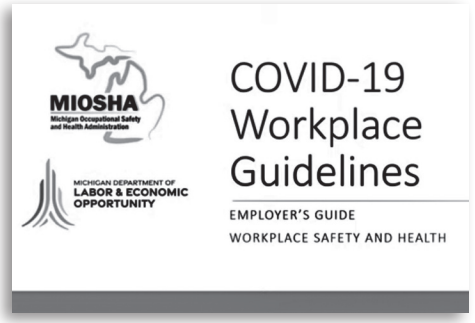
There's a lack of support for performance reporting

Compared to educational stewardship efforts, physicians were less supportive of measuring and providing feedback on antibiotic prescribing practices. Most felt that antibiotic use reports would require significant financial and time investments. Others argued that with antibiotic use measures, some physicians might manipulate the desired outcome to improve their antibiotic prescribing scores.

Additionally, many expressed dissatisfaction and distrust of quality measurement systems and reporting processes. They felt they would be over-measured and blamed for instances that were beyond their control. Lastly, physicians shared issues experienced with the inaccuracy of tracking and reporting systems. This has led physicians to dismiss the use of these reports.

The AMA supports antimicrobial stewardship programs as an effective way to ensure appropriate antibiotic use to reduce the burden of antimicrobial resistance and to improve patient outcomes, as well as incentives to create a sustainable antibiotic research and development enterprise.

MIOSHA Launches New Site for COVID-19 Workplace Safety



MICHIGAN.GOV/COVIDWORKPLACESAFETY
IS ONE-STOP-SHOP FOR WORKPLACE SAFETY RESOURCES AS BUSINESSES REOPEN

The Michigan Occupational Safety and Health Administration (MIOSHA) within the Dept. of Labor and Economic Opportunity (LEO) launched a new online COVID-19 Workplace Safety site - Michigan.gov/COVIDWorkplaceSafety - the site provides guidance and a toolkit of resources to keep workplaces safe as sectors of the state's economy reopen.

With the continued risk of COVID-19 spread, everyone in the workplace must take necessary precautions. The site includes MIOSHA issued guidelines, posters for employees and customers, factsheets, educational videos and a reopening checklist - all of which will help businesses safely reopening their doors.

"As we reengage our economy and begin the long road back to our normal routines, it's critical that we do so safely," LEO Director Jeff Donofrio said. "Michigan.gov/COVIDWorkplaceSafety is designed to make the process of reopening safely easier and equip businesses and their staff with the resources necessary to protect themselves from the spread of COVID-19."

In addition to the general workplace guidelines for employer and employees, MIOSHA provided further clarification on necessary steps several other sectors must take when reopening, including:

- Construction
- Manufacturing
- Offices
- Research laboratories
- Restaurants and bars
- Retail
- Outpatient health care

The site also provides guidance on how employers create and make available to employees and customers, a written exposure control plan which includes exposure determination and outlines measures that will be taken to prevent employee exposure to COVID-19, including as appropriate:

- Engineering controls
- Administrative controls
- Hand hygiene and environmental surface disinfection
- Personal protective equipment
- Health surveillance
- Training

Incorporating the latest guidance for COVID-19 from the U.S. Centers for Disease Control and Prevention (CDC), U.S. Occupational Safety and Health Administration (OSHA) and the Governor's Executive Orders

"Our first priority is to protect workers from the spread of COVID-19," MIOSHA Director Bart Pickelman said. "Employers, employees, and customers who follow these guidelines will help ensure that everyone returns home safe at the end of the day."

Best practices that employees should follow to be vigilant in protecting themselves from exposure to COVID-19:

- Wash hands regularly for at least 20 seconds with soap and water,
- Limit contact with others by remaining six feet apart,
- Clean and disinfect frequently touched surfaces and tools routinely,
- Stay home if you or someone in your household is sick,
- Avoid touching your eyes, nose or mouth, and
- Practice self-screenings to check for any abnormal/new symptoms.

Those with questions regarding workplace safety and health may contact MIOSHA using the new hotline at 855-SAFEC19 (855-723-3219).

To report health and safety concerns in the workplace, go to michigan.gov/MIOSHAcomplaint.

Learn more about MIOSHA and their efforts to protect Michigan's workforce at Michigan.gov/MIOSHA and routinely check the COVID-19 Workplace Safety Guidance toolkit for the latest materials at Michigan.gov/COVIDWorkplaceSafety.

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!*

September/October 2020 Index of Display Advertisers

ADVERTISER	PAGE
Cataract & Eye Consultants of Michigan	11
Henry Ford Macomb Obstetrics & Gynecology	11

2019-2020
Macomb County Legislator Contact Guide

Michigan Senate

Senate District 8
Sen. Pete Lucido (R)
3100 Binsfeld Bldg
(517) 373-7670
SenPLucido@senate.michigan.gov
Term: 1 of 2

Senate District 10
Sen. Michael MacDonald (R)
4200 Binsfeld Bldg
(517) 373-7315
SenMMacdonald@senate.michigan.gov
Term: 1 of 2

Senate District 9
Sen. Paul Wojno (D)
6300 Binsfeld Bldg
(517) 373-8360
SenPWojno@senate.michigan.gov
Term: 1 of 2

Senate District 25
Sen. Dan Lauwers (R)
S-2 Capitol Bldg
(517) 373-7708
SenDLauwers@senate.michigan.gov
Term: 1 of 2

Michigan House

House District 18
Rep. Kevin Hertel (D)
697 Anderson Bldg.
(517) 373-1180
KevinHertel@house.mi.gov
Term: 2 of 3

House District 22
Rep. John Chirkun (D)
786 Anderson Bldg.
(517) 373-0854
johnchirkun@house.mi.gov
Term: 3 of 3

House District 24
Rep. Steve Marino (R)
788 Anderson Bldg.
(517) 373-0113
SteveMarino@house.mi.gov
Term: 2 of 3

House District 25
Rep. Nate Shannon (D)
789 Anderson Bldg.
(517) 373-2275
NateShannon@house.mi.gov
Term: 1 of 3

House District 28
Rep. Lori Stone (D)
792 Anderson Bldg.
(517) 373-1772
LoriStone@house.mi.gov
Term: 1 of 3

House District 30
Rep. Diana Farrington (R)
794 Anderson Bldg.
(517) 373-7768
DianaFarrington@house.mi.gov
Term: 2 of 3

House District 31
Rep. William Sowerby (D)
795 Anderson Bldg.
(517) 373-0159
WilliamSowerby@house.mi.gov
Term: 2 of 3

House District 32
Rep. Pamela Hornberger (R)
796 Anderson Bldg.
(517) 373-8931
PamelaHornberger@house.mi.gov
Term: 2 of 3

House District 33
Rep. Jeff Yaroch (R)
797 Anderson Bldg.
(517) 373-0820
JeffYaroch@house.mi.gov
Term: 2 of 3

House District 36
Rep. Doug Wozniak (R)
885 Anderson Bldg.
(517) 373-0843
DouglasWozniak@house.mi.gov
Term: 1 of 3

MI House Health Policy Committee Members
Pamela Hornberger (R), District 32
Lori Stone (D), District 28
Douglas Wozniak (R), District 36

MI Senate Health Policy Committee Members
Michael MacDonald (R), District 10
Paul Wojo (D), District 9