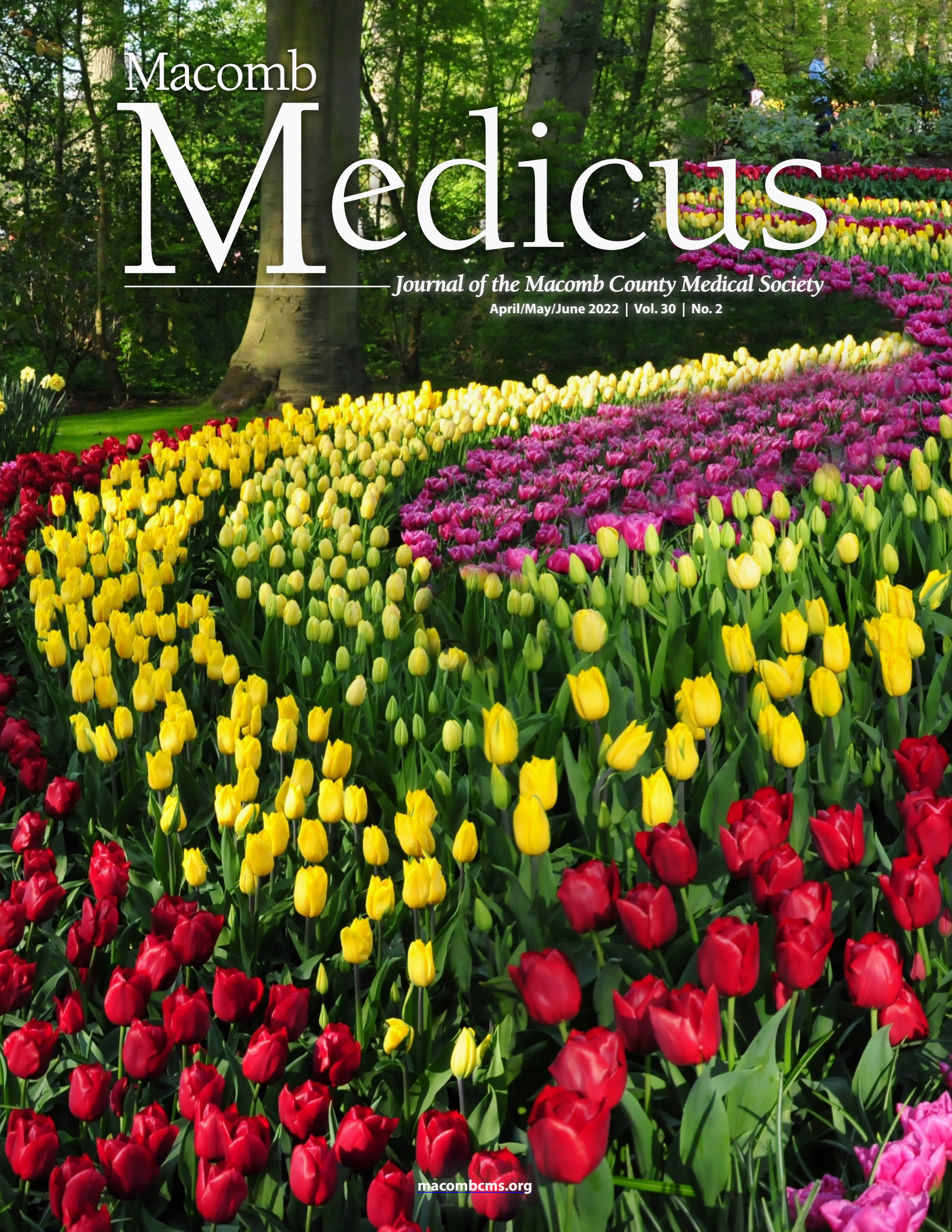

Macomb Medicus

Journal of the Macomb County Medical Society

April/May/June 2022 | Vol. 30 | No. 2

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Macomb Medicus

Journal of the Macomb County Medical Society

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Address changes and all communications relative to articles and advertising in the Macomb Medicus should be addressed to: Editor, Macomb County Medical Society, P.O. Box 551, Lexington, Michigan 48450-0551 or email macombcms@gmail.com.

All material for publication, including advertisements, must reach the Society office no later than the 10th (business) day of the month preceding the date of issue, e.g. December 10 for the Winter issue. Thank you.

The Goat – Greatest Football Player of All Time & Medical Marvel

By: Aaron W. Sable, MD

In February Tom Brady teased retirement but ultimately decided he's not done yet. His brief retirement (six weeks) caused fans to review the full scope of his career under a new lens. Although, fans appreciate the QB's winning ways (7 Super Bowl wins), his courage to play hurt and still lead his team to impressive victories is unrivaled. His success has been shared by family, teammates, and coaches. Not to be overlooked are the contributions of his medical, surgical, and rehabilitation teams which kept him on the field.

For all of the praise heaped upon him for being the GOAT, Tom Brady is rarely if ever talked about as being a tough guy. However, other than missing the 2008 season due to a torn knee, from the age of 32 to 43 years old, Brady has missed zero games due to injury. When you play in the NFL for 20-plus years that means you've played while injured a lot. Tom Brady is not only a tough guy he is an athletic marvel, and a Medical Marvel, to withstand and recover from the violent injuries that are served up in the NFL.

*Includes the 15 weeks he spent on IR for a torn ACL in 2008.

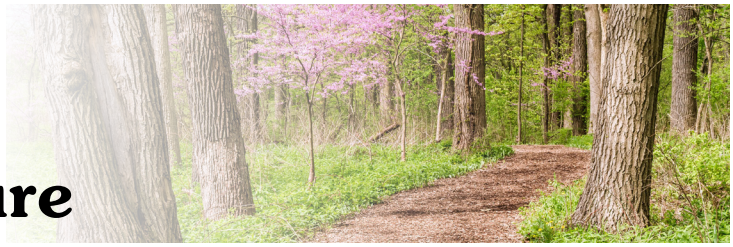
Here is a history of Tom Brady's injuries:

2002-03 Separated Right Shoulder (surgically repaired in 2004)
2007 High Right Ankle Sprain
2008 Knee ACL Tear Grade 3 (had surgery and missed the 2008 season)
2009 3 Broken Ribs & Broken Right Finger
2010 Pedal Foot Fracture (surgically repaired in 2011)
2011 Separated Left Shoulder
2013 Ligament Damage to Right Hand
2014 Leg Calf Strain
2014 Pedal Ankle Sprain Grade 1
2018 Lacerated Right Hand
2019 Right Elbow Sprain
2021 Knee MCL Tear Grade 3 (he had offseason surgery to repair a torn MCL that he originally suffered during his final season with the New England Patriots in 2019)

Hopefully the unretired Tom Brady will not require further medical/surgical treatment before he finally decides to hang up the cleats. ✦

HIS SUCCESS HAS BEEN SHARED BY FAMILY, TEAMMATES, AND COACHES. NOT TO BE OVERLOOKED ARE THE CONTRIBUTIONS OF HIS MEDICAL, SURGICAL, AND REHABILITATION TEAMS WHICH KEPT HIM ON THE FIELD.

Your Next Doctor's Prescription Might be to Spend Time in Nature



By: Michael Precker, American Heart Association News

Dr. Robert Zarr loves to write prescriptions that you don't have to take to the pharmacy.

Instead, he sends patients outside to soak in the healing powers of nature, combining the benefits of exercise with the therapeutic effects of fresh air and green space.

"Going back millions of years, we've evolved outdoors," said Zarr, a pediatrician who recently relocated to Ottawa, Canada, from Washington, D.C. "Why should we exist indoors? We need to be outdoors. The health benefits of being in nature are obvious."

The idea isn't new. The 16th century Swiss physician Paracelsus declared that "the art of healing comes from nature, not from the physician." In Japan, public health experts promote shinrin-yoku, or forest bathing, as a key to physical and psychological health.

The premise is backed up with science. **A 2018 meta-analysis in the journal Environmental Research** reviewed more than 140 studies and found exposure to green space was associated with wide-ranging health benefits, including lower blood pressure and cholesterol, and lower rates of diabetes, stroke, asthma, heart disease and overall death.

In a **2020 study in Frontiers in Psychology**, researchers analyzed 14 studies involving college students and concluded that as little as 10 minutes of sitting or walking in natural settings reduced stress and improved mental health.

"There's an increasing amount of evidence that time in nature as opposed to time in an indoor environment is beneficial," said Donald Rakow, associate professor at Cornell University's School of Integrative Plant Science in Ithaca, New York, and one of the 2020 study's authors. "Being out in nature is not going to solve every mental or physical condition, but it really can be part of an overall treatment approach."

The Environmental Research analysis called for more studies to establish why nature promotes better health, but suggested several possibilities, including the benefits of sunlight, the idea that microorganisms in nature can strengthen our immune systems and the mere fact that being outside encourages physical activity.

Zarr didn't need more convincing. What he wanted was a way to get doctors and their patients to take the health benefits of nature more seriously. So in 2017 he founded Park Rx America, a nonprofit that encourages health care professionals to incorporate nature into their treatment plans. "Prescribing nature is not part of our training," he said. "And then the environment we work in is often so sterile. Doctors don't get much time outdoors during the day, so maybe it's not on our minds."

Why an actual prescription?

"It does make a difference," Zarr said. "The likelihood of doing what you intend to do goes up when you write it down. And the Rx symbol is universal. It's an easy way for people to relate."

Park Rx America has signed up more than 1,000 health care providers and partnered with other organizations to promote the strategy. Its website **www.parkrxamerica.org** provides a prescription template, but one size doesn't fit all.

Rather than assign an activity and a location, Zarr and his colleagues ask patients what they can do and like to do, whether it's sitting on a bench or running a marathon, before writing it up.

"If they say, 'I see myself eating lunch outside,' I say, 'OK, let's start there,'" he said. "It might be the only time they breathe fresh air. Over time we'll change the prescription."

At Cornell, where academic rigor leads to stress, the health clinic encourages students to spend more time outside and incorporate nature prescriptions into their electronic health records.

"It really makes a difference," said Rakow, who co-directs a network of more than two dozen colleges around the country implementing similar programs. "Whether it's an antibiotic or nature, people are much more inclined to follow up when they know that their health professional has prescribed it."

Both experts are confident the trend is growing and that the bad effects of COVID-19 – more time indoors, anxiety, weight gain, to name a few – underscore the need and the desire to get outside.

"The pandemic really firmed up my opinions on this," Zarr said. "It's put a strain on everyone. We need to get out of the virtual world and go outdoors."

Rakow hopes for an awakening similar to what he saw during the years he directed the Cornell Botanic Gardens.

"Each year at the reunions, alumni would visit and ask, 'When did they build this?'" he said. "I would tell them, 'It's always been here.'" ✦

Originally published by the American Heart Association News October 19, 2021

Thank You Letters

January 27, 2022

Dear MCMS Foundation,

Thank you for your incredible gift of $3,471, proceeds from your annual Holiday Sharing Card fundraiser. Achieving our mission is not possible without the support of generous donors like you!

As we approach our 42nd year, Turing Point is committed to building on its foundation of empowering domestic and sexual violence survivors through access to the following free, comprehensive programs and services: an Emergency Shelter, Housing Program, Trauma Advocacy and Counseling, a 24-Hour Hotline, Personal Protection Order (PPO) assistance, Legal Advocacy, a Forensic Nurse Examiner Program, First Response Advocacy, and Community and Prevention Education.

Last year, we established new Transitional and Rapid Re-Housing programs to eliminate the barrier to safe, affordable housing many survivors face when they leave the shelter. Today, over 30 families have a safe place to call home, where their children can grow and thrive without the threat of violence. Over the next year, we will continue to expand the housing programs, providing much-needed stability for families in crisis.

"The housing program has helped me in so many ways; mentally, physically, and emotionally. It has also literally given me and my five children stability and has been a safe haven providing structure for them and me. I could not be more appreciative, nor could I thank this program enough for saving me."
– Housing Program Resident

Thank you for joining us as we work toward a future free of domestic and sexual violence. We are grateful for your support.

Thank you so much for this gift it is truly appreciated!

Sincerely,

Sharman Davenport, PhD
President and CEO, Turning Point

Parks and Trails in Macomb County

Macomb County is home to 3,800 acres of parks and extensive trail systems that you can encourage your patients to utilize. For more information check out https://living.macombgov.org/living-movemore-parkstrails

Find a park near you using SEMCOG's Park Finder https://maps.semcog.org/ParkFinder/ online or download the app for free! You can filter by location, park type and park size. You can also find park amenities including trails, sports facilities and more.

February 15, 2022

Dear Supporters,

On behalf of the Macomb Food Program and its Board of Directors, we would like to extend a sincere "thank you" for your generous donation of $3,781 to the Macomb Food program!

The Macomb Food Program serves people in need of food throughout the County of Macomb through its network of over 70 pantry distribution sites. Every dollar donated is used to purchase food to help feed hungry families, children, the elderly and disabled in our community. Last year, with the help of generous donors, we were able to feed nearly 500 people per day, with some of our pantries reaching much higher numbers due to the pandemic.

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

Thank you for your generous donation and continued support!

Gratefully,

Robert Combs
Chairperson

Shannon Mallory
Program Manager

Amid Doctor Shortage, NPs and PAs Seemed Like a Fix. Data's In: Nope.

By: Andis Robeznieks, Senior AMA News Writer

Hattiesburg Clinic's value-based care journey illustrates the power of data analysis—and the vital importance of physician-led team-based care.

An examination of cost data for the South Mississippi system's accountable care organization (ACO) revealed that care provided by non-physician providers working on their own patient panels was more expensive than care delivered by doctors.

This prompted Hattiesburg Clinic leaders to redesign the clinic's care model and to publish their findings. Hattiesburg Clinic employed a total of 26 physician assistants (PAs) and nurse practitioners (NPs) in 2005 and today there are 118. Along with certified registered nurse anesthetists and optometrists, they are part of a team of 186 non-physician providers at the clinic, also called advanced practice providers (APPs).

"Over the past 15 years, in the face of physician shortages, especially in primary care, Hattiesburg Clinic made decisions to expand our care teams with the use of advanced practice providers," says a study entitled "Targeting Value-based Care with Physician-led Care Teams" that was published in the Journal of the Mississippi State Medical Association.

"Focusing specifically on primary care, because our shortage of physicians there was so dire—due to retirements, massive panel sizes and lack of medical students entering primary care residencies—we allowed APPs to function with separate primary care panels, side by side with their collaborating physicians," the study adds.

In hindsight and "with a wealth of internal data," which includes cost data on more than 33,000 patients enrolled in Medicare, "the results are consistent and clear: By allowing APPs to function with independent panels under physician supervision, we failed to meet our goals in the primary care setting of providing patients with an equivalent value-based experience."

A private multispecialty clinic with more than 300 physicians, Hattiesburg Clinic is a member of the AMA Health System Program. Its ACO was ranked first in quality in its cohort in 2016 and 2017, amongst a total of 471 other participants, and has been recognized by the Centers for Medicare & Medicaid Services (CMS) for delivering high-quality care at a low cost.

The 2017–2019 CMS cost data on Medicare patients without end-stage renal disease and who were not in a nursing home showed that per-member, per-month spending was $43 higher for patients whose primary health professional was a non-physician instead of a doctor. This could translate to $10.3 million more in spending annually if all patients were followed by APPs, says the analysis. When risk-adjusted for patient complexity, the difference was $119 per member, per month, or $28.5 million annually.

Data analysis sparks system changes

"We didn't set out to do a scientific study per se. This was really an observational experience that used data to help us drive decision-making going forward," said internist Bryan N. Batson, MD, a co-author of the study and CEO of Hattiesburg Clinic.

"This was us looking in the mirror to say: As we're becoming more advanced in value-based care, how do we do it better?" Dr. Batson added.

After receiving the first CMS reports on care costs, the original intent was to identify the highest-cost physicians and work with them to cut spending.

"When we got the claims data for the first time, one of the first things we did was to look at who our highest-cost providers were" Dr. Batson said. "We were a little bit surprised at how stark the differences were, at the most-costly end of the spectrum between physicians and advance practice providers."

"We dug a little further and used risk-adjustment analyses. It appears that the additional costs had to do with a combination of several factors that included more ordering of tests, more referrals to specialists, and more emergency department utilization," he added.

Nephrologist John M. Fitzpatrick, MD, president of Hattiesburg Clinic and another co-author of the study, said "four of the five top highest-cost providers were nurse practitioners." That finding "prompted us to really analyze the whole population and, ultimately, led to the findings in the paper."

In fact, patients who saw a non-doctor as their primary care provider (PCP) had higher rates of ED use than patients without a PCP.

The data also showed that physicians performed better on nine of 10 quality measures, with double-digit differences in flu and pneumococcal vaccination rates.

"This was surprising, as these are typically considered 'process' measures that can be adequately handled by non-physician staff," the study says.

Physicians also had higher average patient-satisfaction scores across six domains measured by Press Ganey.

Drs. Batson and Fitzpatrick praised NPs and PAs as invaluable members of the Hattiesburg care team without whom thousands of patients would go without care.

"However, based on a wealth of information and experiences with them functioning in collaborative relationships with physicians, we believe very strongly that nurse practitioners and physician assistants should not function independently," the study says.

Fueled by the data, leaders at Hattiesburg Clinic redesigned its care model so that a doctor is the PCP all patients see and that no one sees a non-physician exclusively.

"We had a one-year transition period leading up to that, so that the nurse practitioners could tell their patients that beginning Jan. 1, 2021, you're going to have alternating visits with me and my supervising physician, but your PCP will officially be the physician," Dr. Batson said.

"I give great credit to the nurse practitioners and PAs who work in our organization—almost all of them were very much supportive of this change in the model and have adapted and helped educate the patients on why we were making these changes. They continue to be great team players, and we are very thankful to them," he added.

More robust use of telemedicine has also helped with implementation of the new care-team model.

"It really changes the way that we're able to deliver health care in a rural setting—in a positive way—such that a clinic may be able to be staffed some days with an APP, some days with a physician, but in those days that the APP is the lead there, there's the availability of telemedicine to support more advanced health care delivery," Dr. Batson said.

Patients deserve care led by physicians—the most highly educated, trained and skilled health care professionals. Through research, advocacy and education, the AMA vigorously defends the practice of medicine against scope-of-practice expansions that threaten patient safety. ✦

Free MSMS On Demand Webinars

Available at www.msms.org/Education

Grand Rounds Webinar Series:

A Message from Your MAC: Depression Screening,
.75 CME Credit.

Navigating the No Surprises Act,
.75 CME Credit

Sharing Clinical Notes With Patients: A New Era of Transparency in Medicine,
.75 CME Credit

Changes to Michigan's Auto No-Fault Act for Physicians,
.50 CME Credit

Federal Information Blocking Rules,
1 CME Credit

CURES Act - What is Information Blocking and How Do I Comply?,
1 CME Credit

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.75 CME Credit

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.75 CME Credit

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Practice Management Webinar Series:

Resources to Navigate Surprise Billing Requirements,
.5 CME Credit

HHS Portal Reporting,
.5 CME Credit

Henry Ford Macomb Hospital

HENRY FORD HEALTH REVEALS EVOLVED BRAND

New signs. Updated website. New ads in the media. These and other activities were revealed in March, signaling the dynamic evolution of the Henry Ford Health brand. The new identity emphasizes our devotion to partnering with patients, communities, and workforce along the entire health journey. Along with the new identity, we also premiered a new campaign called "I Am Henry". Click here to see our 60-second spot that highlights our values as an inclusive employer, an innovator, and advocate for building strong, healthy communities.

The refreshed Henry Ford Health name and new logo clearly transitions the identity from one steeped in the visual history of founder Henry Ford, to a brand expression focused on humanity, backed by a powerful heritage of innovation and drive. The organization's "new signature" is a tribute to its century-plus legacy, while infusing a bright and bold new look.

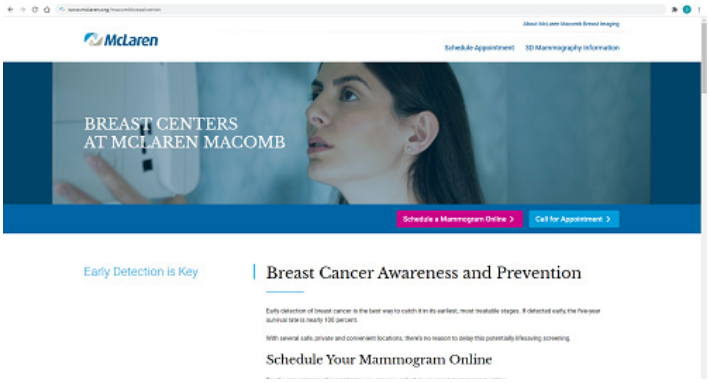
PATIENT SAFETY AWARD

Henry Ford Macomb Hospital is one of 13 hospitals in Michigan to receive the 2022 Hospital Patient Safety Award from the Economic Alliance for Michigan (EAM), a nonprofit group comprised of Michigan's largest employers and union. The award recognizes hospitals in Michigan with consistent high marks and improvements in patient safety and quality of care.

CENTER OF EXCELLENCE ROBOTIC SURGERY ACCREDITATION

Henry Ford Macomb Hospital has been accredited by SRC (Surgical Review Corporation) as a Center of Excellence in Robotic Surgery. **Raed Alnajjar, MD, cardiothoracic surgeon**, and **Ryan Nelson, DO, urologist,** have been accredited as Surgeons of Excellence in Robotic Surgery. SRC is an internationally recognized, nonprofit, patient safety organization dedicated to recognizing and refining surgical care. This accreditation recognizes robotic surgery programs that demonstrate an unparalleled commitment and ability to consistently deliver safe, effective, evidence-based care.

McLaren Macomb Hospital



URGING SCREENINGS, MCLAREN MACOMB INTRODUCES MAMMOGRAM ONLINE SCHEDULING

In an effort to increase the ease of access to potentially lifesaving breast cancer screenings, McLaren Macomb has expanded its breast centers to include online scheduling.

This move was motivated to combat the pandemic-induced delay in regular screenings.

With five breast center locations throughout Macomb County, patients can view all open appointments and choose the one that best fits their schedule all in a few clicks at www.mclaren.org/macombbreastcenters.

"Over many years I've heard firsthand from countless women who've credited their regular mammogram with catching their cancer early and setting them up for a successful treatment," said Pat Keigher, director of cancer services at the Karmanos Cancer Institute at McLaren Macomb. "This makes the trend of patients delaying their screening more concerning. Cancers are being diagnosed in later stages, and treatments are having to become more invasive. I can't stress screenings enough."

One of the more troubling and lasting secondary effects of the COVID-19 pandemic has been the delay or complete postponement of health screenings—mammograms being a leading screening—resulting in patients being diagnosed at later stages, with the disease progressed.

Five McLaren Macomb Breast Centers are located through the county: Mount Clemens, Clinton Township, Shelby Township, Lenox and Lenox Township.

JIM WILLIAMS, PHD, RN, MSN, CENP, NAMED MCLAREN MACOMB CHIEF OPERATING OFFICER

McLaren Macomb has named Jim Williams, PhD, RN, MSN, CENP, to its executive leadership team as the hospital's vice president and chief operating officer.

Williams assumes the role vacated by previous COO Tim Vargas, who was promoted within McLaren Health Care to president and chief executive officer at McLaren Lapeer Region hospital. Williams comes to McLaren Macomb with more than 20 years of progressive hospital executive experience, having most recently served as chief nursing officer at McLaren Flint.

"Nursing is vital to any hospital's overall operation, and it's unique in how it interacts with so many different departments," Williams said. "This has provided an invaluable perspective and a wealth of experience for me. I'm excited to join this organization and grow in my career, and to bring this perspective to the hospital, my new role and our overall operations."

Throughout his career, Williams' increasing experience in both nursing and operations has resulted in achieving operational enhancements, work force development and facility expansion.

McLaren Macomb is in the midst of its latest expansion with the opening of the Harrington Medical Center and Ambulatory Surgery Center, across from the hospital's main campus, scheduled to open in the summer. This comes on the heels of several recent expansion projects.

"Within our own health care system, Jim has already demonstrated his ability to be a capable leader and dedicated health care professional," said Tom Brisse, McLaren Macomb president and CEO. "His skill set will fit in well at McLaren Macomb, especially considering our recent expansions and plans for continued growth. We are excited to welcome Jim and his wealth of experience as a respected hospital leader to our team."

In this role, Williams will provide administrative oversight and leadership to several hospital service lines and future expansion projects while also supporting hospital leadership's identification and development of long-range planning.

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 NEUROLOGIST ADDS BOTOX® FOR TREATMENT OF CHRONIC MIGRAINES

Alex Steinbock, DO, FACN, a board-certified neurologist at McLaren Macomb, has expanded his practice by adding Botox® injections to his treatment options for painful and debilitating chronic migraines.

With this treatment approved by the FDA, chronic migraines are defined as at least 15 headache days every month with at least eight of those occurrences featuring classic migraine symptoms:

- Pain on one side of the head
- Pain that throbs or pulses
- Sensitivities to light, sound, smell and/or touch
- Nausea with/without vomiting

"Chronic headaches can really hamper anyone's overall quality of life, and as the frequency and severity of these occurrences increase, the more debilitating the results can be," Dr. Steinbock said. "Migraines are the most common complaint I get from my patients, and to now have a safe, proven treatment that will have a lasting impact on them is an advantage for everyone."

The third most common disease worldwide, migraines affect one in every seven Americans, and it's the second leading cause of years lived with a disability, second only to chronic back pain. While the cause of migraines is unknown, they trigger abnormal nerve, chemical and vascular activity in the brain, resulting in increasingly intense pain and symptoms.

Botox®, as a treatment option, blocks the brain's pain network from activating. Injected near the pain fibers associated with headaches, the substance enters the nerve endings and blocks the release of chemicals that transmit pain.

Covered by most insurances, Dr. Steinbock administers the injections in his office — a single dose every three months. Multiple patient studies have reported a significant reduction in the number of days every month they had a migraine (or any type of headache) while also reporting more pain-free days.

For more information, or to make an appointment with Dr. Steinbock, visit www.mclaren.org/steinbock. ✦

We would like to welcome the following New Members

Douglas C. Kubek, DO
Otolaryngology – Board Certified, Otolaryngology/Facial Plastic Surgery – Board Certified, Sleep Medicine – Board Certified
Medical School: Midwestern - Chicago College of Osteopathic Medicine, 1995. Post Graduate Education: Botsford-Beaumont Hospital, completed in 1996; St. John Macomb-Oakland Hospital, completed in 2000. Hospital Affiliations: Ascension Macomb-Oakland, Ascension St. John, McLaren Macomb, Beaumont Grosse Pointe. Currently practicing at Lakeshore Ear, Nose, Throat Center, 20111 E. 12 Mile Rd., Ste. 111, St. Clair Shores, MI 48081, p. 586-779-7610, f. 586-779-003, www.lakeshoreent.com

Marie A. McDonald, MD
Pediatrics – Board Certified
Medical School: American University of the Caribbean School of Medicine, 1987. Post Graduate Education: St. Joseph's Mercy Oakland, completed in 1989; Medical College of Wisconsin, completed in 1991. Currently practicing at Shelby Pediatric Associates, 15125 22 Mile Rd., Shelby Twp., MI 48315, p. 586-532-0599, www.shelbypediatricassociates.com.

Katherine J. Yulo, MD
Pediatrics – Board Certified
Medical School: University of Santo Tomas Faculty of Medicine & Surgery (Philippines), 2004. Post Graduate Education: Driscoll Children's Hospital (TX), completed in 2010. Hospital Affiliations: Troy Beaumont. Currently practicing at Shelby Pediatric Associates, 15125 22 Mile Rd., Shelby Twp., MI 48315, p. 586-532-0599, www.shelbypediatricassociates.com.

We would like to welcome our New Resident Members

Ascension Macomb-Oakland Hospital

Safa Abdalla, MD
Zachary Adkins, MD
Manar Almasry, MD
Ahmad Alosh, MD
Ahmad Al-Sahli, MD
Brian Barnett, DO
Jorawar Brar, DO
Trisha Chaudhury, DO
Anthony Cook, DO
Nathan Cowdin, DO
Zachary Cox, DO
Yael Duer, DO
Kurt Erhardt, MD
Rhett Fullmer, MD
Himaja Gaddipati, DO
Ronny Hadid, MD
Ermal Hasalliu, DO
Alexander Helfand, MD, PhD
Noah Hochstetler, DO
Mohammad Hussain, MD
Yoonho Hwang, MD
Fares Jamal, DO
Dillon Jarbo, MD
Jack Komro, DO
Joseph Lynch, DO
Adam Mizeracki, MD
Khalid Mohammed, DO
Taiwo Opaleye-Enakhimion, M.B.Ch.B.
Katherine Reyburn, MD
Romenette Rivera, DO
Jose Rodriguez Dager, DO
Mitchell Ross, MD
Anthony Seely, MD
Judy Sheffeh, MD
Prachi Shukla, DO
Vincent Skovira, MD
Lianne Wagner, DO
Joshua Wahlstrom, MD
Shamaiza Waqas, MBBS
Julie Ward, MD
Kathryn Zapata, MD

Henry Ford Macomb Hospital

Jacob Archutowski
Julia Bank
Michelle Barbat
Elizabeth Barrett
Nathan Booth, DO
Angelo Brennan
Jaila Campbell
Fatima Charara
Allison Cole
Danielle Collins, DO
Sarah D'Souza
Kate Fitzgerald
Nakul Gandhi
Sabrina Harinandan
Elena Hunsanger
Ali Hussain
Nicolas Longobardi
Ricardo Melendez Rodriguez
David Naimzadeh
Amanda Najor
Asiyah Nathani
Connor Olzem
Jennifer Orellana, DO
Sarah Pender, DO
Guillermo Polanco Serra, MD
Cameron Schneider
Ahmed Selim
Diana Singh
Hannah Streeter
Francesca Tiberio
Aaron Walkowski
Shelby Willey
Christine Wolf
Areej Zaheer
Cindy Zhang
Kristopher Zuhl

Public Health Communications COLLABORATIVE

Knowing what misinformation is being shared can help you generate effective messaging

The following alerts are from the **Public Health Communications Collaborative**

- 🔴 High risk alerts: We recommend directly addressing and debunking the misinformation
- 🟡 Medium risk alerts: We recommend monitoring the situation but not actively engaging

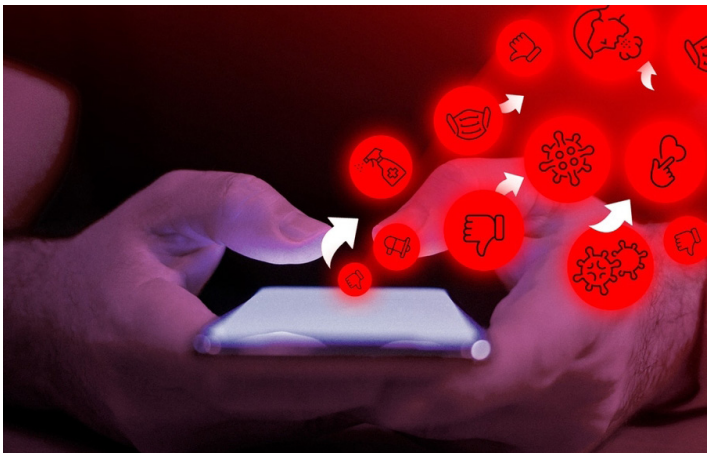
Conspiracy post misleadingly links COVID-19 vaccination to fetal death

A post in an online conspiracy community claims that data from the FDA shows a more than 16,000 percent increase in fetal death following COVID-19 vaccination. The post's claim is a misleading interpretation of VAERS data, which cannot be used to determine if an adverse event, like fetal death, is directly linked to vaccination. Between 10 and 20 percent of pregnancies end in miscarriage or stillbirth. The rate is not different for those who were vaccinated while pregnant. Research shows that COVID-19 vaccination does not increase the risk of pregnancy complications, birth defects, miscarriages, or stillbirths.

Recommendation: 🔴 Direct Response

There is understandable concern over whether COVID-19 vaccines impact fertility or pregnancy. Recent studies, however, show that COVID-19 vaccines are safe for both pregnant people and anyone trying to become pregnant in the future. Informational materials may emphasize that COVID-19 poses a risk to pregnant people; people who are infected during pregnancy are at increased risk for severe illness, hospitalization, preterm birth, stillbirth, and other pregnancy complications. Explaining that vaccination is suggested for people who are pregnant and breastfeeding is recommended.

In addition, VAERS or other vaccine safety monitoring systems are often used incorrectly, sometimes deliberately in order to spread misinformation and disinformation. VAERS allows anyone to submit reports of vaccine injury or side effects; these claims do not have to be verified. After claims are made, government health experts perform investigations to determine whether reported injuries or side effects were due to vaccines. This is why only official government reports and peer-reviewed scientific studies should be trusted. Emphasizing that these reporting systems contain unverified reports while directing to actual evidence is recommended, as is continuing to explain what mild side effects people can expect after vaccination.



Vaccine side effect study misrepresented by vaccine skeptics

Vaccine opponents are misrepresenting a recent study that assessed a group of 15 children who were diagnosed with myopericarditis (inflammation of heart muscles) after receiving the Pfizer COVID-19 vaccine. Of the 15 patients, 10 had abnormal cardiac activity when evaluated. A physician with a large online following who has previously spread vaccine misinformation posted that 63 percent of children in the study experienced the abnormality without clarifying that the study only included a small group of children experiencing a rare vaccine side effect. The post also fails to mention that all of the children improved quickly after receiving treatment.

Recommendation: 🔴 Direct Response

There is understandable and widespread concern about the potential for rare side effects after child vaccination. Responding with empathy and acknowledging the concerns of parents is recommended, as is explaining how vaccination will help protect both children and their families. Informational materials may emphasize that vaccines have been rigorously tested to make sure that they are safe for all vaccinated individuals, including children, and that adverse side effects are extremely rare. Reminding people that millions have died from COVID-19 and that the vaccines are our best way to keep more people from dying is also recommended, as is explaining that a child is at a much higher risk of myopericarditis from a COVID-19 infection than they are from the vaccine.

Anti-vaccine activist falsely claims vaccinated people will have AIDS by year-end

A prominent anti-vaccine activist who previously made headlines for claiming that COVID-19 vaccines can magnetize people is now promoting the false claim that "every vaccinated person over 30" will develop vaccine-induced AIDS by the end of the year. Vaccine-induced AIDS is not a real condition, and COVID-19 vaccines don't impair the immune system.

Recommendation: 🟡 Passive Response

continued on page 12

Myths connecting COVID-19 to AIDS are continuing to spread online. Emphasizing that there is no link between COVID-19 and HIV or AIDS is recommended. Medical experts agree that the COVID-19 vaccines do not cause or make people more susceptible to HIV or AIDS and that the shots don't weaken the immune system. They strengthen it. Updating materials to debunk claims about HIV and the COVID-19 vaccines is recommended, as is monitoring local conversations about so-called "VAIDS."

Vaccine opponents equate flu, COVID-19 to disparage vaccines

A video clip has resurfaced that features Dr. Anthony Fauci in a 2004 interview saying that a recent influenza infection provides sufficient protection to skip the flu shot. Vaccine opponents are using the clip to claim that reliance on "natural immunity" should apply to COVID-19 vaccines. COVID-19 and the flu are not the same disease and should not be treated as such. Health authorities recommend COVID-19 vaccination for people who have recovered from COVID-19 because the vaccine provides more reliable protection. Among people who have had COVID-19, those who are vaccinated are significantly less likely to be re-infected than those who remain unvaccinated.

Recommendation: Passive Response

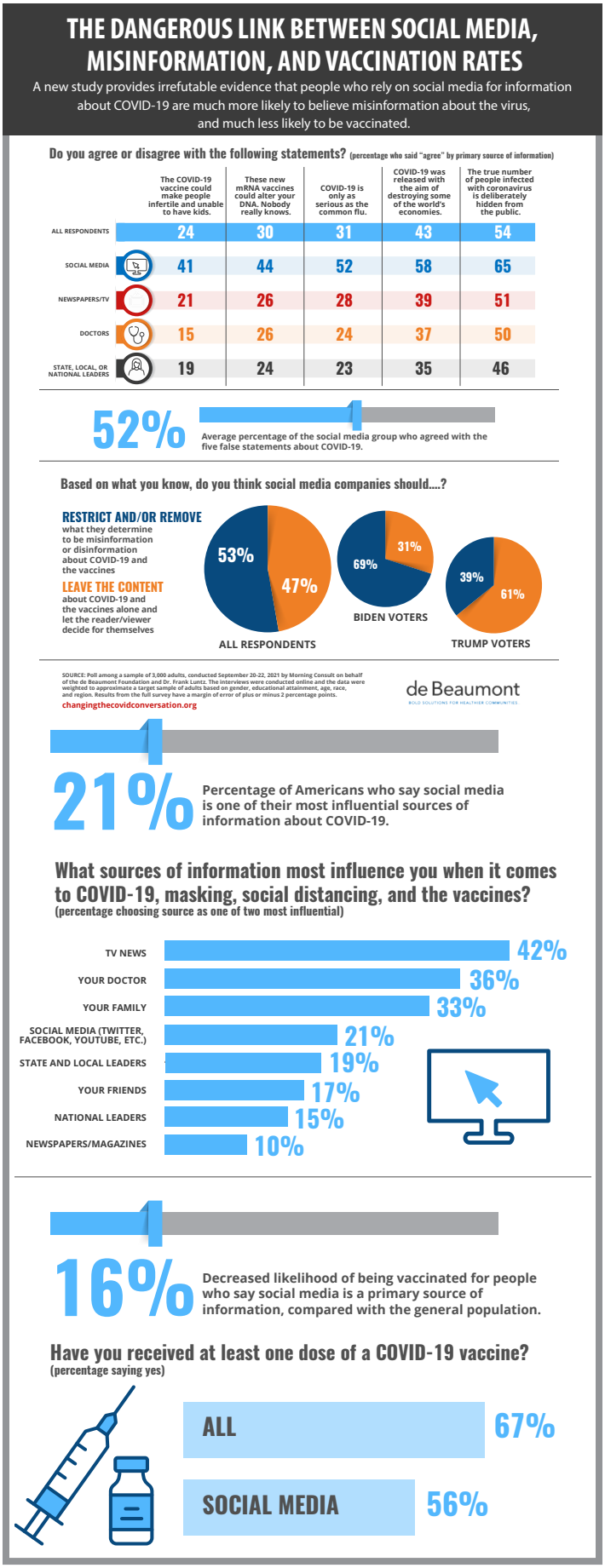
Emphasizing that the flu and COVID-19 are different illnesses, and that the vaccine recommendations and other suggested protective measures are therefore different for each illness, is recommended. Emphasizing that there is no safe way to acquire natural immunity is also recommended. While a COVID-19 infection can provide protection, vaccine-acquired immunity is more reliable and a lot less risky.

Article falsely claims more military deaths from vaccine than COVID-19

An article that is trending on conservative social media falsely claims that VAERS data shows that there have been more military deaths caused by COVID-19 vaccines than from COVID-19. No evidence is provided to support the claim, and it's unclear how VAERS reports specifically linked to service members would even be identified. According to the Department of Defense, COVID-19 has killed 682 members of the U.S. military.

Recommendation: Passive Response

VAERS or other vaccine safety monitoring systems are often used incorrectly, sometimes deliberately in order to spread misinformation and disinformation. VAERS and similar systems allow anyone to submit reports of vaccine injury or side effects; these claims do not have to be verified. After claims are made, government health experts perform investigations to determine whether reported injuries or side effects were due to vaccines. This is why only official government reports and peer-reviewed scientific studies should be trusted. Emphasizing that these reporting systems contain unverified reports while directing to actual evidence is recommended, as is continuing to explain what mild side effects people can expect after vaccination. ✦



These 3 Measures will Help Doctors Boost Diabetes Prevention

By: Sara Berg, MS, Senior AMA News Writer

With health declining faster and higher costs of type 2 diabetes beginning at least five years before diagnosis, prevention is key. But physician practices and health systems across the country lack a standardized way to measure quality care for prediabetes. To help, the AMA convened a cross-specialty, multidisciplinary technical expert panel to identify and define quality measures for prediabetes.

These measures aim to support the prevention of type 2 diabetes in the U.S., focusing on increased screening and testing for prediabetes, referral for intervention, and follow-up testing. The recommendations of this technical expert panel resulted in the first diabetes-prevention measurement set in the country for use at the individual physician and group practice level.

"Only about one in seven people who have prediabetes are aware or have been told by their physician that they have prediabetes," said Ronald Ackermann, MD, MPH, co-chair of the AMA's Prediabetes Quality Measures Technical Expert Panel. "The problem is we have effective interventions for prevention, but it requires that we detect prediabetes."

"We're missing opportunities every day to prevent type 2 diabetes," Dr. Ackermann added.

The measures are intended to be "implemented feasibly by a practice or a health system to track and then improve its ability to screen for prediabetes and to offer proven-effective resources that can prevent type 2 diabetes," he said. Here are the three new prediabetes quality measures physicians should consider using to help gauge their diabetes-prevention efforts.

Screening for abnormal blood glucose

This measure focuses on making sure that people who should be screened for prediabetes and type 2 diabetes receive a lab test, according to the United States Preventive Services Task Force.

"It turns out that particularly among people who have risk factors for diabetes … they're getting blood tests often for other reasons," said Dr. Ackermann. "Somewhere between 50% and 75% or more of those individuals had a glucose test, but very few of them will actually have evidence that they received a diagnosis of prediabetes or that they had access to a service that was an intervention to prevent diabetes.

"In most cases, we can be confident that a test wasn't conducted to detect prediabetes specifically, even though it can be used that way," he added. "It means that a lot of people already get these tests, and there's an opportunity to use current testing by health systems to identify more people quickly and make them aware."

"It's feasible for the health systems to develop strategies to identify prediabetes because the necessary tests are already common, and about six in seven high risk people are already seeing a health care provider at least once each year," said Dr. Ackermann.

Intervention for prediabetes

"The second measure is if you do screen positive, if you have a blood test that shows you have prediabetes, are we offering interventions?" said Dr. Ackermann. "It's really about setting goals for modest weight loss—usually 10 to 20 pounds—by increasing physical activity and making healthful dietary changes."

"From the standpoint of using the measures, you would need a strategy for how you will offer the interventions," he said. "There are a range of options, but that's still a difficult area for health systems if there's not a lot of nearby community providers offering a proven-effective behavioral intervention program."

There are now more than 1,800 organizations in the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program, including many virtual options. This provides patients and physicians with many prediabetes interventions to choose from.

Retesting of patients with prediabetes

"If you have prediabetes, we are retesting you so that it's not a one and done—it's a longitudinal consideration," said Dr. Ackermann. "By monitoring, it allows you to be accountable and to have systems in place that you can actually reach the end goal of preventing type 2 diabetes by keeping everyone with prediabetes on a prevention plan."

"We wanted to have measures across that whole continuum so that a health system could actually implement a whole approach to prediabetes," he said, adding that "you can choose one measure and not all three, but the idea is they actually will work very nicely together to create a systemic approach to diabetes prevention."

The AMA's **Diabetes Prevention Guide** supports physicians and health care organizations in defining and implementing evidence-based diabetes prevention strategies. This comprehensive and customized approach helps clinical practices and health care organizations identify patients with prediabetes and manage the risk of developing type 2 diabetes, including referring patients at risk to a National DPP lifestyle-change program based on their individual needs. ✦

Attracting Qualified Candidates in a Tight Labor Market

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

Q. ***Like many employers in this job market, we are struggling to recruit new staff. We have many positions unfilled including nurses, medical assistants and office staff. What are some new strategies we might try to stand out from our competitors and attract qualified candidates to our practice?***

A. You are right. It is a tight labor market right now. The "great resignation" that started in 2021 and continues into 2022 is leaving many jobs unfilled and employers struggling. Michigan currently has 190,000 fewer people in the workforce as compared to pre-pandemic numbers and a labor force participation rate of 59.5%; 41st lowest in the nation. These trends mean that the labor shortage is unlikely to change anytime soon.

So, how can your practice stand out from others and attract qualified candidates? There are several strategies you might consider beyond what you may already do as part of your traditional recruiting process. This job market is forcing employers to adapt their way of doing business.

1. **Offer more part-time positions.** Providing more part-time options may be attractive for several reasons including offering flexibility with child care arrangements and supporting more work-life balance. Women make up the majority of medical practice and office staff. Women are still primarily responsible for handling home and child care arrangements for their families and after becoming a parent, women are more likely to switch to a job with greater flexibility. Offering part-time positions may appeal to trained staff that left the workforce previously, enticing them to rejoin. Also, don't forget about your current employees. Offering a part-time option may help retain existing staff who are experiencing burnout.

   Of course, there are additional considerations when offering part-time options, including decisions on what benefits to offer and scheduling considerations, but these costs and logistical details may pay off in recruiting and retaining talent. Start by talking with your existing employees about their interest in part-time options. You can also test out the option with a couple of staff to assess how it works and then decide to expand from there.

2. **Consider offering evening appointments**. You may be thinking, what does evening scheduling have to do with recruiting and retaining staff? Along with part-time options, there are a segment of workers who may appreciate working non-traditional hours, including those who have someone at home able to provide child care in the evening. You may have patients who appreciate this option too!

3. **Provide additional benefits.** Support with child care costs and continuing education may give you the edge as compared with other practices. If you don't already offer retirement match and/or student loan payment assistance, these can set you apart too.

4. **Pay attention to your image.** With a tight labor market, employees can be choosier on where they want to work. Employees want to work at practices that treat their staff and patients well. If your patient reviews are not positive overall (more than just a periodic bad review), it could mean that there are other issues happening in the practice that need attention. Discontent in a practice not only impacts patient satisfaction, but employee recruitment and retention as well. And if there are other employment options that look more attractive as a place to work, high quality employees will choose to apply somewhere else.

   In addition to paying attention to online reviews, spend some time marketing your practice online via social media and your website. Potential employees are researching your practice and you want them to see a place that looks like a great place to work.

5. **Build your future workforce.** Do you have office staff who are interested in learning a clinical role or clinic or medical assistants who are burned out with direct patient care and interested in working in business operations? Do you partner with your local high school career institute, community college or advanced degree programs by providing internships, clinical rotations or other shadowing opportunities for students/residents? Building up your talent pipeline is a long-term strategy to cultivate your future workforce.

While these strategies may not be an immediate fix, together they can help build and retain a high-quality workforce for the long term. ✦

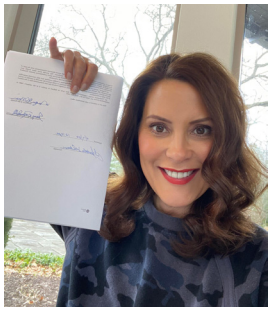
By: Daniel M. Ryan, MD, MSMS Region 2 Director

PRIOR AUTHORIZATION REFORM HAS BEEN SIGNED INTO LAW

More than three years ago, physicians, patients and other health professionals and advocacy associations, led by the Michigan State Medical Society, joined together to create Health Can't Wait. This coalition was formed to develop and enact into law legislation that would put Michigan patients first and end delayed access to vital health care services. Throughout this time, MSMS physicians and our coalition partners shared countless stories of the ways prior authorization caused unnecessary and costly care delays and interfered in medical decision-making. We are happy to report that after years of hard work your voices have been heard!

On April 7, 2022, Governor Gretchen Whitmer signed Senate Bill 247 into law. Senate Bill 247 reforms the prior authorization process by reducing wait times and streamlining how physician offices and payers interact, all with a goal of reducing endless paperwork and ultimately improving access to care for patients.

"Today is a wonderful day for Michigan patients who can now rest easy knowing insurance company prior authorization practices will no longer prove to be an impassable roadblock between them and the timely care and treatment they too often desperately need," said MSMS President Pino Colone, MD. "Speaking on behalf of providers, patient advocacy groups and patients across the state, I want to thank Governor Whitmer and Michigan's lawmakers for recognizing the need for reform in this area and then working to craft and enact legislation that delivers. In signing SB 247, Governor Whitmer has ushered in new era where transparency, clinical validity and fairness to patients will all be factored into the prior authorization process, protecting Michigan patients from costly and dangerous delays in access to health care. Officially signing this bill into law is a tremendous—and much needed—win for countless Michigan patients and the providers who serve them."



Senate Bill 247 will reform the prior authorization process to do the following:

- Require an insurer to make available, by June 1, 2023, a standardized electronic prior authorization request transaction process.
- Require prior authorization requirements to be based on peer-reviewed clinical review criteria.
- Require an insurer to post on its website if it implemented a new prior authorization requirement or restriction or amended an existing requirement or restriction.
- Require an insurer to notify, on issuing a medical benefit denial, the health professional and insured or enrollee of certain information, including the right to appeal the adverse determination, and require an appeal of the denial to be reviewed by a health professional.
- For a medical benefit that is not a prescription drug benefit, an insurer shall notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 60 days before the requirement or restriction is implemented.
- For a prescription drug benefit, an insurer shall notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 45 days before the requirement or restriction is implemented.
- Prohibits an insurer or its designee utilization review organization from affirming the denial of an appeal unless the appeal was reviewed by a licensed physician.
- For urgent requests, beginning June 1, 2023, the prior authorization is considered granted if the insurer fails to act within 72 hours of the original submission. For non-urgent requests, beginning June 1, 2023, the prior authorization is considered granted if the insurer fails to act within 9 calendar days of the original submission. After May 31, 2024, a non-urgent prior authorization is considered granted if the insurer fails to act within 7 calendar days of the original submission.
- Requires an insurer to adopt a program that promotes the modification of prior authorization requirements of certain prescription drugs, medical care, or related benefits, based on the performance of the health care providers with respect to adherence to nationally recognized evidence-based medical guidelines and other quality criteria (i.e., BCBSM "gold carding" program).

MSMS FOUNDATION'S SPRING EDUCATIONAL PROGRAMS

The MSMS Foundation is pleased to announce our spring educational program lineup is now open for registration.

Grand Rounds Live Webinar Series

MSMS Grand Rounds is our monthly webinar series that covers a wide range of pressing topics for physicians and their practice. From updates on the Omicron variant, to the child and adolescent mental health crisis, and LGBTQ health in Michigan. Grand Rounds is free to members and is available to view live or watch the recording at your convenience. Each program will offer .75 AMA PRA Category 1 CME Credit.

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Practice Management Live Webinar Series

This new series will provide practical information on the day-to-day operations of your practice and are designed for both physicians and their medical staff. From HHS portal reporting to navigating surprise billing and protection from embezzlement. The MSMS Practice Management Series is free and can be viewed live or watch the recording at your convenience. Each free program will offer 1 AMA PRA Category 1 CME Credit.

Monday Night Medicine

Our spring Monday Night Medicine program will focus on implicit bias training. This two-part program will be held on April 4 and May 9, 6:30-8 pm as a live virtual event and will fulfill the new requirement for licensure. Debra Furr-Holden, PhD, Associate Dean for Public Health Integration, Director, Division of Public Health, Michigan State University and Jennifer Edwards-Johnson, DO, MPH, Assistant Professor, Community Assistant Dean, Michigan State University, Flint will co-present.

Spring Scientific Meeting

This year's Spring Scientific Meeting will be held as a live virtual event. We are pleased to offer six 3-hour courses on April 7-8, May 12-13, and June 9-10 for a total of 18 AMA PRA Category 1 Credits™. All courses will be held from 8-11 am. Join us to hear local and national experts cover practice gaps in Endocrinology, Palliative Care, Allergy and Asthma, Infectious Diseases, and Lymphedema.

Implicit Bias Monthly Training Series

The MSMS Foundation is working with state-wide experts in diversity and equity on our brand-new curriculum for our monthly training series. A one-hour webinar will be recorded and available on the MSMS website. This session will have one-hour of CME. However, to meet the implicit bias requirement, physicians will need to return for a live, online virtual session. These will take place once per month. Anyone who has completed the archived recording, can choose one of the live sessions to complete the implicit bias credit. They will receive another half credit for the live session. Please note, the implicit bias requirement for licensure has the additional criteria of a live component and pre and post assessments and differs from the other mandated CME areas.

For more information and to register visit **www.msms.org/eo**

MSMS AWARDED $200K GRANT FROM THE W.K. KELLOGG FOUNDATION TO FUND NEW HEALTH EQUITY INITIATIVE

Working to bolster its commitment to advancing equity across all aspects of the health care system, the Michigan State Medical Society (MSMS) is set to begin on Partnering to Advance Health Equity—a new project designed to identify strategies and opportunities to better position and support physician leadership in their ongoing efforts to reduce—and ultimately eliminate—the racial and ethnic health disparities that persist throughout Michigan communities.

"The COVID-19 pandemic has served as a stark reminder that health inequities absolutely persist within our health care system, with people of color bearing a disproportionate burden of cases and deaths throughout the pandemic," said **Theodore Jones, MD, Chair of MSMS's Task Force to Advance Health Equity**. "Working to eliminate the inherent structural and systemic racism baked into our health care system that lead to these kinds of disparate health outcomes is a huge priority for MSMS. This grant from the W.K. Kellogg Foundation will go a long way towards getting us there."

For MSMS and the Partnering to Advance Health Equity project, that effort starts with working to better understand the types of support physicians need to lead change in their respective communities at the system level and via care delivery. Through the project, MSMS will employ a variety of strategies to determine, prioritize and facilitate the best course of action to advance health equity including:

- Surveying Michigan's physicians.
- Learning about replicable initiatives from other professional organizations.
- Working with the American Medical Association to implement evidence-based, health disparity-conscious best practices in Michigan.
- Convening stakeholders' meetings that will provide opportunities to share lived and living experiences, listen to local concerns and needs, and identify partners interested in mitigating health care gaps, disparities, and inequities.

"Thanks to this grant from WKKF, MSMS and physician leaders across the state are ultimately going to be in a much better position to make sure organized medicine is responsive to community needs, rebuilds trust, and provides leadership in all communities throughout Michigan, providing every patient with the opportunity to achieve optimal health," said Julie Novak, MSMS CEO. "That's certainly something worth celebrating and we're excited to get started."

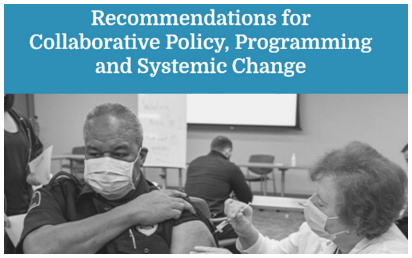
UPDATE TO FAQS ON OSHA'S HEALTHCARE ETS

As guidance related to COVID-19 continues to evolve at federal, state, and local levels, many medical practices are asking questions about the continued need to implement various mitigation strategies such as screening and masking. In order to provide further clarification, the Michigan

State Medical Society's Legal Counsel provided an **update on the status and application of the Healthcare Emergency Temporary Standard ("Healthcare ETS")** announced by the Occupational Safety and Health Administration's ("OSHA") last June.

MICHIGAN CORONAVIRUS RACIAL DISPARITIES TASK-FORCE REPORT OUTLINES SIGNIFICANT PROGRESS, POLICY RECOMMENDATIONS IN PROTECTING COMMUNITIES OF COLOR FROM COVID-19

The first-of-its-kind Michigan Coronavirus Racial Disparities Taskforce released recommendations for collaborative policy, programming and systemic change to protect communities of color from the spread of COVID-19 and create lasting structural change. The report, which provides a progress report on the taskforce's short- and long-term goals, finds that actions taken by the State of Michigan in 2020 and 2021 helped reduce health-based racial disparities in COVID-19 response and deaths.



A study by the Duke-Margolis Center for Health Policy and the National Governors Association Center for Best Practices found that Michigan Coronavirus Task Force on Racial Disparities has made significant and sustainable progress towards its goal of reducing health-based racial disparities associated with the COVID-19 pandemic.

Upon formation, the Task Force took immediate action to address racial health disparities and proposed solutions to address disparities. Key actions implemented to address racial disparities of the COVID-19 pandemic included reducing barriers to testing in communities of color, expanding testing to the most at risk for serious illness, developing culturally competent messaging for best practices of COVID-19 mitigation, improving racial data collection and sharing, and improving access to health care for marginalized populations.

The Task Force also developed two additional work groups that provided input and recommendations related to racial disparities in environmental justice and telemedicine. The environmental justice workgroup was established to address the environmental issues that play a significant role in the health and welfare of communities of color. The access to telemedicine workgroup was established to address the disproportionate access communities of color experience when seeking doctors and primary care services.

The full report can be found by clicking here.

NEW COVID WEBSITE

On March 30th, the Biden administration launched **COVID.GOV**. Many of the COVID-19 related resources and questions you, or your patients, may have, are now located on one simple site. With a click of a button, you, or your patients, will be able to access:

- Latest CDC data on the level of COVID-19 in your community
- Free masks
- Locations to receive a vaccine or booster
- How to order 2 sets of 4 free at-home rapid tests
- Insurance reimbursement opportunities
- Guidance on travel
- Locations of 20,000+ free testing sites
- New test-to-treat sites, where you can get tested and if possible, get lifesaving treatments right away. There are currently 2,000 of these sites across the country, including local pharmacy clinics, community health centers and health clinics that serve veterans and families.
- And much more ✦

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!

UPCOMING EVENTS

May 9, 2022 ~ Implicit Bias Training, Session 2
MSMS Monday Night Medicine Series, Live Webinar, 6:30 pm – 8 pm, 1.5 AMA/PRA Category 1 CME Credits. These sessions will fulfill the new LARA requirement for implicit bias training. Cost: $75 members, $100 non-members.

May 11, 2022 ~ LGBTQ Health in MI: An Overview of Efforts to Improve Care & Reduce Health Disparities
MSMS Grand Rounds, FREE Live Webinar, 12 pm – 12:45 pm, .75 AMA/PRA Category 1 CME Credits.

May 11, 2022 ~ Practice Management - Embezzlement: How to Protect Your Practice
MSMS Practice Management Series, FREE Live Webinar, 1 pm – 2 pm, 1 AMA/PRA Category 1 Credit.

May 12-13, 2022 ~ MSMS Spring Scientific Meeting
Live Webinar, 8 am – 11 am, 6 AMA/PRA Category 1 CME Credits. Cost: $60 members, $120 non-members.

May 13, 2022 ~ 8th Annual Henry Ford Cancer Institute Head & Neck Cancer Symposium
7:30 am – 3:00 pm, Orchard Lake Country Club in West Bloomfield, 6.25 AMA/PRA Category 1 Credits.

May 14, 2022 ~ Henry Ford Cancer Institute Gastrointestinal & Neuroendocrine Multidisciplinary Symposium
7:45 am – 3:00 pm, The Dearborn Inn in Dearborn, 6 AMA/PRA Category 1 Credits.

May 24, 2022 ~ Long COVID and Post-Viral Syndromes
MSMS Live Webinar, 6:30 pm – 8 pm, 1.5 AMA/PRA Category 1 CME Credits.

June 8, 2022 ~ Emotional and Personal Resiliency: Moving Through Burnout
MSMS Grand Rounds, FREE Live Webinar, 12 pm – 12:45 pm, .75 AMA/PRA Category 1 CME Credits.

June 8, 2022 ~ Practice Management - Office Billing Policies and Procedures for No Surprises
MSMS Practice Management Series, FREE Live Webinar, 1 pm – 2 pm, 1 AMA/PRA Category 1 Credit.

June 9-10, 2022 ~ MSMS Spring Scientific Meeting
Live Webinar, 8 am – 11 am, 6 AMA/PRA Category 1 CME Credits. Cost: $60 members, $120 non-members.

June 15, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

July 13, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

August 10, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

September 21, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

October 12, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

November 16, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

November 30, 2022 ~ Implicit Bias Monthly Training Series
MSMS Live Webinar, 12 pm – 12:30 pm, .5 AMA/PRA Category 1 CME Credit.

Michigan Supreme Court Greatly Expands Damages Available in Medical Malpractice and Other Wrongful Death Cases

By: Daniel J. Schulte, J.D., MSMS Legal Counsel

Q. ***It was recently reported that our Supreme Court refused to hear a case that greatly expanded the damages available to plaintiffs in wrongful death cases (arising from medical malpractice or other claims). Can you explain this decision? Is it significant?***

A. The case that you refer to is Estate of Langell v McLaren Port Huron. The plaintiff estate alleged medical malpractice against several defendants. The issue on appeal was whether the plaintiff estate was entitled to recover as damages an amount approximating all the potential future earnings of the decedent or only an amount approximating the future financial support obligation of the decedent (a more limited amount).

The Court of Appeals held that the plaintiff estate was entitled to recover all the future earnings of the decedent without regard to whether the decedent had a financial support obligation. Defendants filed an application for leave to appeal to the Supreme Court. MSMS and the AMA filed an amicus brief supporting the defendants' application and arguing that this element of the plaintiff estate's damages should be limited to the decedent's financial support obligation.

The applicable section of Michigan's Wrongful Death Act, MCL 600.2922(6), provides:

In every action under this section, the court or jury may award damages as the court or jury shall consider fair and equitable, under all the circumstances including reasonable medical, hospital, funeral, and burial expenses for which the estate is liable; reasonable compensation for the pain and suffering, while conscious, undergone by the deceased during the period intervening between the time of the injury and death; and damages for the loss of financial support and the loss of the society and companionship of the deceased. (emphasis added)

This statute specifically states that "damages for the loss of financial support" are recoverable. It does not provide that all the future earnings of the decedent are recoverable. Despite this choice of language by the Michigan legislature, our Supreme Court decided to let stand a Court of Appeals decision allowing an award of damages including a loss of all future earnings without regard for whether the decedent owed anyone an obligation of financial support. The Supreme Court's 5-2 decision was contained in an order denying defendants'

application for leave to appeal. The majority (Justices Bernstein, Clement, Cavanagh Welch and McCormack) included no substantive explanation supporting their denial in the order. Justices Viviano and Zahra dissented and provided an explanation. They believed the Supreme Court should have granted leave to appeal to fully consider this "significant and recurring question of law involving a complicated statute." Justices Viviano and Zahra further stated their opinion that the Court should have heard the appeal to consider the applicable precedent, Baker v Slack, 319 Mich 703 (1948). In Baker the Supreme Court held that the previous version of MCL 600.2922(6) limited a plaintiff estate's recovery to the amount of the decedent's support obligation and did not allow all the future earnings of the decedent to be recovered as damages. Justices Viviano and Zahra openly questioned whether Baker remains "good law" and would have heard this appeal and addressed that question.

The denial of the application for leave to appeal in Langell is significant. In future medical malpractice cases involving the death of a patient and other cases brought pursuant to Michigan's Wrongful Death Act plaintiffs will now seek the full loss of the earnings capacity of the decedent whether the decedent had a support obligation or not. This will be the case until the Supreme Court decides to hear an appeal which fully interprets MCL 600.2922(6) considering its history and Baker. ✦

Are Physicians Prohibited from Responding to Online Patient Reviews?

The myth

Physicians are prohibited from responding to online patient reviews.

Background

Numerous websites provide information about clinicians and organizations from which patients seek health care. Some of these sites provide user-submitted reviews about practices and clinicians from patients or members of the public. Unfortunately, patient reviews are not always positive, and can sometimes be negative, inflammatory, or false. Negative or false reviews can adversely, and sometimes seriously, affect a physician, their practice, reputation and their career. To avoid these potential consequences, physicians may feel compelled to respond to reviews to address concerns or rectify problems but are fearful they will run afoul of the law and patient privacy protections if they do.

Debunking the myth

There are no federal laws or regulations prohibiting physicians or practices from responding to online patient reviews; however, unlike other businesses that may respond to online reviews in any way they deem appropriate, physicians are limited in what and how they can communicate with a patient reviewer in a public forum.

Acknowledgement of a patient's relationship with the provider might risk violating patient privacy protected by the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws. It is important to note that HIPAA does not explicitly prohibit physicians from responding to online reviews; physicians are free to respond and contribute to an online review forum, but they must maintain the privacy of the patient's protected health information (PHI), even if the patient has already revealed personal information. While a patient is free to share any information about their experience in an online forum, physicians are prohibited from disclosing any patient-specific information.

Most, if not all, online review sites have openly published community review guidelines or standards. Physicians and practices do have the option to contact the review sites directly to dispute false or inflammatory reviews, especially if they believe the reviews violate the site's community standards.

Physicians are encouraged to consider these suggestions when deciding whether and how to respond to online reviews.[1]

- Don't disclose any information about the patient—don't even acknowledge the person is a patient in your office. Even if a patient has disclosed their information in an online review, remember that HIPAA prevents a physician from disclosing any information about a patient without the patient's permission. A patient's own disclosure is not permission for the doctor to disclose anything.
- Consider taking the response offline. Sometimes, personal contact results in the patient taking down the negative review, or results in the patient adding an online review that lets other patients know your office is listening.
- Speak about general policies and standard protocols if you chose to respond online. For example, if a patient is upset that they did not receive an antibiotic, a physician could respond, not by mentioning anything about the specific patient, but instead by saying that office policy and standard medical practice is to determine if a patient has a viral or bacterial infection and to only prescribe antibiotics when there is a bacterial infection is present.
- Remember, one bad review will not destroy your online reputation. Patients look at a physician's overall rating and when there are many good reviews, a few bad ones will not stand out as the norm.
- Don't respond immediately. Take a deep breath and walk away.
- Don't ignore criticism. Instead, objectively look at the criticism from the patient's point of view and determine whether there is something you or your office can do differently.
- Don't shy away from online reviews. Ask your patients to rate and review you online. In most cases, reviews are positive. And remember that many positive reviews dilute many negative reviews.

Practices are required to provide HIPAA training to appropriate staff and are encouraged to develop policies and procedures related to appropriate disclosures of PHI, with special attention paid to avoiding disclosures on social media. ✦

References

[1] Henry TA. How to respond to bad online reviews. American Medical Association News. 2016. Available from: https://www.ama-assn.org/delivering-care/patient-support-advocacy/how-respond-bad-online-reviews.

Disclaimer: The AMA's Debunking Regulatory Myths (DRM) series is intended to convey general information only, based on guidance issued by applicable regulatory agencies, and not to provide legal advice or opinions. The contents within DRM should not be construed as, and should not be relied upon for, legal advice in any particular circumstance or fact situation. An attorney should be contacted for advice on specific legal issues.

AMA AMERICAN MEDICAL ASSOCIATION

STOPPING MISINFORMATION, RESTORING TRUST ARE STEPS ON SAME JOURNEY

By: Gerald E. Harmon, MD, AMA President

Overt politicization of the pandemic—and the speed with which falsehoods about all aspects of COVID-19 have spread online, over the airwaves and through media—are major reasons why the U.S. has suffered a far greater COVID-related death toll than other large, well-resourced nations.

The recent controversies about misinformation widely circulating on popular streaming services and social media have renewed calls for greater oversight and enforcement of these media channels. But how can we accomplish that without infringing on our right to free speech?

As physicians, we too often bear the brunt of such efforts to mislead and confuse the public, and must speak out against purveyors of junk science and conspiracy theories. We must work to address the pandemic that long preceded COVID-19: a pandemic of mistrust.

Ensuring greater accountability

We need greater responsibility on the part of the corporations who run these platforms to recognize and limit the spread of disinformation and other falsehoods related to COVID-19, vaccination or related subjects, and help their viewers and listeners distinguish fact from fiction. We need a firm commitment by members of Congress and other elected officials to ensure that those who spread lies and disinformation are held accountable for their actions.

History will judge us harshly if we fail to change the course we have taken to date, which has brought us so much division, disinformation and death—unnecessary death in so many cases. With safe and effective vaccines widely available, and a base of knowledge about this virus that continues to expand, the fact that some 1,500 Americans are still losing their lives to COVID-19 every day is inconceivable at this stage in the pandemic.

The unchecked spread of unintentional misinformation and purposeful disinformation across various platforms has sowed confusion and mistrust while heightening vaccine hesitancy and refusal. This in turn has triggered violence against physicians, nurses and other health professionals, along with a host of other negative consequences.

Consequences of lost trust

One of the most dangerous and deeply troubling of those consequences has been the widespread loss of trust in science, in organized medicine, in units of government, and in the public health institutions that we depend on for the credible, unbiased, evidence-based information we need to make sound decisions about our own health and the well-being of those we care for.

Some of the damage has been self-inflicted. Early in the pandemic, mixed messaging about masking from the Centers for Disease Control and Prevention (CDC) was a misstep that weakened the agency's ability to render what proved to be sound guidance about the vital importance of masking up. In other cases, the damage has been inflicted upon us through disinformation campaigns directed by both foreign governments and domestic extremist groups, as documented by the Department of Homeland Security.

At the same time, we cannot overlook the fact that a small number of licensed physicians continue to foster belief in scientifically unvalidated and potentially dangerous "cures" for COVID-19, which has increased vaccine hesitancy and fueled further politicization of the pandemic. Their actions violate the ethics of our profession and jeopardize the trust found at the center of the patient-physician relationship. Our AMA continues to urge state medical boards to respond swiftly and decisively when physicians spread falsehoods.

Trust must be earned

Of course, the CDC, Food and Drug Administration and other agencies at the federal, state and local levels must do their part to earn and keep our trust, just as physicians and other health professionals must do. Among other steps, this will require a higher level of cooperation among these institutions, a renewed emphasis on consistent and scientifically sound public health messaging, and a greater level of transparency that demonstrates a complete lack of outside interference in formulating and issuing the guidance that helps save lives.

With the Omicron peak behind us, we all anxiously await the chance to embrace some semblance of the lives we led before

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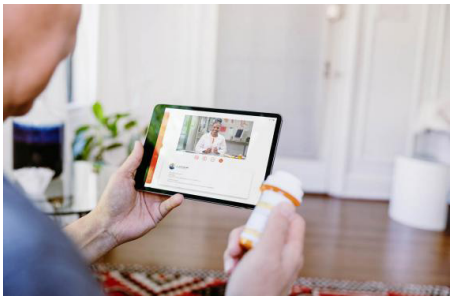
the pandemic struck. Ending the pandemic of mistrust that has grown in tandem with COVID-19 is an equally important goal that is also within our reach.

TELEHEALTH FLEXIBILITIES ASSURED FOR THE BULK OF 2022

Patients and physicians who have come to see the immense clinical value of telehealth throughout the COVID-19 pandemic can breathe a sigh of relief that access to this useful mode of care will continue for at least another five months after the Biden administration declares an end to the nation's public health emergency (PHE).

The provision is one of many related to health care included in the massive, $1.5 trillion spending bill—called the Consolidated Appropriations Act, 2022—that was passed and garnered headlines for including $13.6 billion in emergency aid for Ukraine.



"Congress has taken a crucial step in starting a revolution in patient access. The AMA aims to continue being a partner in moving it forward," said AMA President Gerald E. Harmon, MD. "The dramatic increase in adoption of telehealth that occurred in 2020 has allowed medical care that combines in-person and virtual services to become the new standard of care. This new legislation guarantees that patients with Medicare will continue to benefit from this important innovation in health care delivery."

The AMA and a vast array of more than 300 health care organizations urged congressional leaders to take this step as a way of "facilitating a pathway to comprehensive permanent telehealth reform that would provide certainty to beneficiaries and our nation's health care providers while providing sufficient time for Congress and the administration to analyze the impact of telehealth and patient care."

AMA ASKS CONGRESS NOT TO ADOPT MedPAC RECOMMENDATION TO CONTINUE MEDICARE PHYSICIAN PAYMENT FREEZE

The AMA has sent a letter to Congressional leaders underscoring the systemic shortcomings of the current Medicare physician payment system that are highlighted in a new report from the Medicare Payment Advisory Commission (MedPAC).

The AMA comments stress the importance of Congress not adopting MedPAC's recommendation to allow the freeze in Medicare fee for service physician payment rates provided by current law to continue and instead asks Congress to establish a stable, annual payment update that keeps pace with practice cost inflation, similar to other Medicare providers and Medicare benefit categories. Medicare Advantage plans, for example, are projected to see nearly an 8% payment increase in 2023.

Following are highlights of the AMA's comprehensive response to the MedPAC report:

- The AMA comments highlight that data from the Medicare Trustees indicate that Medicare physician payment has been reduced 20%, when adjusted for inflation, from 2001–2021, establishing a widening gap between physician payment rates and rising medical practice costs.
- The letter stresses that Medicare spending per enrollee has been falling for physician payment schedule services even as it has risen steeply for other Medicare benefits.
- The comments highlight that the statutory freeze in annual Medicare physician payments is scheduled to last until 2026, when updates resume at a rate of only 0.25% a year indefinitely, well below the rate of medical or consumer price index inflation.
- The AMA also stresses that physicians are being asked to do more with fewer resources each year and continue to face significant clinical and financial disruptions during the COVID-19 pandemic.

Also of note, most physicians have not had opportunities to transition to value-based Medicare Advanced Alternative Payment Models, as Congress intended, and must comply with the costly and burdensome Medicare Merit-Based Incentive Payment System. ✦

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LEGISLATIVE UPDATE

Take Action and Contact your Legislators

Urge your Senator to Support Increased Funding for Primary Care!

The Medicaid uplift, which applies to both adult and pediatric primary care services, will expand access to care for Medicaid beneficiaries, support primary care and physician practice sustainability, and improve patient health.

Vote YES on SB 828

Support Telehealth Parity

House Bill 5651 will require payment and coverage parity for telemedicine services the same as if the service were provided in-person, ensuring patients have access to quality care while allowing telehealth to remain a sustainable option for physicians to offer.

Vote YES on HB 5651

Nurse Scope of Practice Expansion

Senate Bill 680 will allow for full independent practice for nurse practitioners (NPs). Under the bill, not only would NPs be allowed to provide direct care without physician supervision or collaboration, they would also be allowed to prescribe opioids and other controlled substances. Further, the bill wouldn't even require additional training or education for NPs.

Vote NO on SB

Tell your Lawmaker to Protect Auto Accident Victims Access to Care

Tell your legislator that you support HB 4486 and SB 314 and that they have a responsibility to protect auto accident victims' right to recover.

Vote YES on HB4486 and SB 314

Support the Push for Behavioral Health Integration

Efforts to reform Michigan's Medicaid program by introducing Senate Bills 597 and 598 are necessary and appreciated. Integrating physical and behavioral health care services is critical to ensure each patient receives the person-centered care required. However, legislation must include a clinical model that removes existing barriers and care delays by advancing seamless integration amongst clinicians across specialties and care settings.

SBs 597 & 598 take some positive steps toward needed integration, however, further improvements are necessary. **Urge Your Senator to recognize the key role primary care plays in the delivery of efficient, effective, and coordinated behavioral health services**.

Urge Your Legislator to Ensure Safe Drinking Water in Michigan Schools

The Filter First approach to reducing lead in school drinking water calls for providing filtered drinking water stations for students and staff in Michigan Public Schools.

Vote YES on SBs 184-185

Thank Michigan Legislators for Passing Prior Authorization Reform

We are happy to report that after years of hard work your voices have been heard! On March 23, 2022, the Michigan House of Representatives passed Senate Bill 247 with overwhelming support (103 yes votes and 2 no votes).

Please write your legislators to thank them for their support of meaningful prior authorization reform for Michigan's patients and providers.

2021-2022 Macomb County Legislator Contact Guide

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Lori Stone (D), District 28

MI House – Regulatory Reform
Kevin Hertel (D) - Minority Vice Chair
Richard Steenland (D), District 22

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