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IN THIS ISSUE

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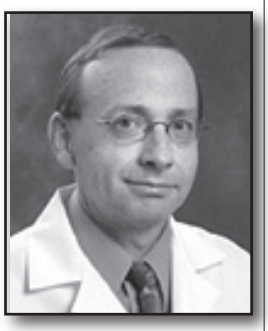
Antibiotic stewardship. We all have to get involved.



By: Vincente Redondo, MD

WHAT IS ANTIBIOTIC STEWARDSHIP? THIS IS A TERM THAT WE ARE GETTING USED TO HEARING, BUT WHAT DOES IT REALLY IMPLY. The definition would be "a series of coordinated strategies to improve the use of antimicrobial drugs with the goal of improving patient health, outcomes, reducing bacterial resistance to antibiotics and decreasing healthcare costs". Hospitals are now required to have an antibiotic stewardship program in place, which usually involves a team approach of infection control practitioners, pharmacists and administrators.

As soon as antibiotics were discovered and their use became widespread, bacteria developed mechanisms of resistance. This was first reported with staphylococcus aureus. As a result, a large body of research was required to develop antimicrobials in order to overcome the new emerging resistance mechanisms. Nevertheless, it appears that in some instances, bacteria are winning this war, as there are reports of bacteria that are resistant to all available antibiotics (particularly through production of metalloproteinases). What is the implication of bacterial resistance for the healthcare system? It is estimated that the cost is twenty billion dollars per year in the United States, and more significantly 23,000 deaths per year, according to the CDC.

It is clear that antibiotics have been an outstanding success. Eliminating or reducing mortality and morbidity from many common infections such as pneumococcal pneumonia that carried a fairly high mortality prior to the antibiotic era.

However, antibiotics can directly cause side effects such as allergic reactions, toxicity (e.g. nephrotoxicity from vancomycin and aminoglycosides), hematologic disorders, renal failure, and hyperkalemia related to Bactrim. Furthermore antibiotics significantly affect the intestinal flora thus allowing the overgrowth of bacteria such as C. difficile which in turn places an immense burden on hospitals and extended care facilities.

It has been estimated that up to 50% of antibiotics prescribed are not needed or are not prescribed appropriately (usually longer duration that necessary). Another great concern, which is beyond the control of medical professionals, is the use of antibiotics in food producing animals. The FDA is taking steps to correct this practice and has issued a guidance to restrict the use of these drugs to only when medically necessary.

But a key question is: does antibiotic stewardship actually work? The answer is yes. There have been several studies done, one recent meta-analysis by Baur et al[1] shows that the incidence of infections and colonization with antibiotic resistant bacteria and Clostridium difficile was significantly reduced in hospitals that have an active antibiotic stewardship program.

In practice what we need to do before we prescribe an antibiotic is similar to what has been implemented in surgical services as a "timeout", where one needs to pause and ponder whether this patient needs to be on antibiotics, if it is the right antibiotic (narrow versus broad spectrum when possible) and lastly determine the right duration of antibiotic treatment (for example we rarely need to treat pneumonia more that 7 days). This approach will make us become more conscious of the impact over prescription of antibiotics has in our health care system as a whole and in our patients in particular and I think we will be more effective and prescribe antibiotics more judiciously.

It should be noted though that antibiotic stewardship has the greatest effect when used in conjunction with infection control measures such as different types of isolation precautions (contact, droplet, airborne). Unfortunately, we often encounter some resistance in compliance with the use of protective gear that is often required, as well as hand washing. The rates of compliance particularly for physicians are not great, although rates vary widely, 60-70% is not unusual.

In conclusion: We as physicians have to be more conscious of our responsibility in the success of antibiotic stewardship programs, trying to prescribe antibiotics judiciously and also complying with infection control measures, both of which will have long lasting beneficial effects on the wellbeing of our patients and financial sustainability of our healthcare system.

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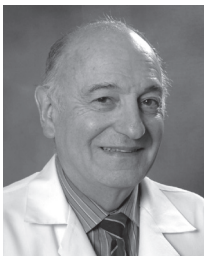
[1]Effect of antibiotic stewardship on the incidence of infection and colonisation with antibiotic-resistant bacteria and Clostridium difficile infection: a systematic review and meta-analysis. Lancet Infect Dis. 2017 Sep;17(9):990-1001. doi: 10.1016/S1473-3099(17)30325-0. Epub 2017 Jun 16.

MICHIGAN DELEGATION REPORTS FOR DUTY



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

National Harbor, Maryland, was the site of this year's American Medical Association (AMA) Interim Meeting on November 10-13. Your Michigan State Medical Society's (MSMS) Delegation to the AMA was actively involved in serving on several reference committees and advocating for Michigan-sponsored resolutions. Delegation Chair, James D. Grant, MD, MBA, noted, "participation and advocacy by the Michigan Delegation definitely had a positive impact on policy outcomes from the AMA House of Delegates. Whether advocating on behalf of Michigan resolutions or representing the interests of Michigan patients on a national level, your Delegation again proved why it is a Delegation to watch."

David T. Walsworth, MD, served as Chair of the Rules and Credentials Committee. The Reference Committee on Amendments to Constitution and Bylaws and Reference Committee F (AMA Governance and Finance) also included Michigan representation as Jayne E. Courts, MD, and Michael D. Chafty, MD, were seated as committee members, respectively.

Three of Michigan resolutions reaffirmed existing policy while the other four were adopted as amended. Like the MSMS House of Delegates (HOD) process, Michigan's Delegation to the AMA must submit and testify on Michigan's resolutions before respective committees to garner support and address any opposition.

Michigan's resolutions adopted as reaffirmation of existing policy are as follows:

- **Resolution 223 -** Permanent Reauthorization of the State Children's Health Insurance Program
- **Resolution 819 -** Medicare Reimbursement Formula for Oncologists Administering Drugs
- **Resolution 821 -** Direct Primary Care and Concierge Medicine Based Practices

Below are Michigan's resolutions that were adopted as amended:

- **Resolution 820 -** Ensuring Quality Health Care for Our Veterans
- **Resolution 920 -** Continued Support for Federal Vaccination Funding
- **Resolution 921 -** Food Environments and Challenges Accessing Healthy Food
- **Resolution 961 -** Protect Physician-Led Medical Education

Additionally, two reports, one from the Board of Trustees (BOT) and the other from the Council on Medical Service (CMS), addressed two Michigan resolutions that were previously referred for additional study. In each report, the recommended action was favorable to the position of the Michigan resolutions and each report was ultimately approved by the HOD. In BOT Report 12, it was determined that having additional information pertaining to animal derived medications would be beneficial for both patients and clinicians. CMS Report 3 studied Michigan's call for additional financial and other resources to help practices quality for and sustain Patient-Centered Medical Home (PCMH) status. As a result, the Report included "a set of recommendations recognizing that it is critical to not only have financial support during the initial stages of practice transformation, but also to maintain ongoing funding and continuous cultural and monetary support for PCMH activities."

DOES YOUR MEDICAL LICENSE EXPIRE JANUARY 31, 2019 - ARE YOU READY TO RENEW?

Did you know that along with the 150 hours of continuing education credits (CME) required to renew, physicians must also have a minimum of 1 hour of continuing education in the area of medical ethics and 3 hours of pain and symptom management?

Separate from continuing education requirements, physicians must also complete a one-time human trafficking requirement. For physicians whose license expires January 31, 2019, this must be completed by January 31, 2022.

License Renewals

Every three years, all Michigan physicians must renew their license and certify compliance with state continuing medical education laws. Every year approximately one-third of Michigan's physicians are required to renew. The Licensure and CME calendar year runs February 1 to January 31. Each physician is required to complete 150 credits of CME in which a minimum of 75 hours of the required 150 must be earned in Category 1 activities, and the 5 required credits in medical ethics (1), pain management (3) and human trafficking (1).

Physicians who have not met the 150 requirement are strongly urged to not renew until all credits have been achieved. Doing so is a violation of the Michigan Public Health Code and is subject to license sanctions. Physicians can take advantage of the 60-day grace period to complete the missing credits. Online renewal must be completed within the 60-day grace period, along with the $20 late fee payment in addition to the renewal fee. Physicians whose

licenses have been expired for more than 60 days must apply for re-licensure.

New Categories of Continuing Medical Education

The Board of Medicine has updated the previous six Categories of Credit into two categories. As before, each medical doctor is required to complete 150 hours of continuing medical education approved by the Board of Medicine, which a minimum of 75 hours of the required 150 must be earned in Category 1 activities, and 5 in the before mentioned areas of medical ethics (1), pain management(3) and human trafficking (1). The following is a breakdown of the two Categories for licensure:

Category 1

A. Activities with accredited sponsorship - *Maximum 150 hours*

B. Passing specialty board certification or recertification - *Maximum 50 hours*

C. Successfully completing MOC that does not meet requirements of (A) or (B) above. - *Maximum 30 hours*

D. Participation in a board approved training program - *Maximum 150 hours*

Category 2

A. Clinical instructor for medical students engaged in postgraduate training program - *Maximum 48 hours*

B. Initial presentation of scientific exhibit, poster or paper - *Maximum 24 hours*

C. Publication of scientific article in a peer-reviewed journal - *Maximum 24 hours*

D. Initial publication of a chapter or portion of a chapter in a professional health care textbook or peer-review textbook - *Maximum 24 hours*

E. Participation in any of the following as it relates to the practice of medicine: - *Maximum 18 hours*

1. Peer review Committee dealing with quality of patient care
2. A Committee dealing with utilization review
3. A health care organization committee dealing with patient care issues
4. A national or state committee, board, council or association

F. Until December 6, 2019, attendance at an activity that was approved by the Board of Medicine prior to December 6, 2016 - *Maximum 36 hours*

G. Independently reading a peer-reviewed journal prior to December 6, 2016, that doesn't satisfy the requirements of Category 1, subdivision (A) - *Maximum 18 hours*

H. Prior to December 6, 2016, completing a multi-media self-assessment program that doesn't satisfy the requirements of Category 1, subdivision (A) - *Maximum 18 hours*

Additional Resources

For more information on CME requirements for re-licensure, please visit: https://www.michigan.gov/documents/lara/LARA_Medicine_CE_Brochure_5-11_376428_7.pdf

LARA LICENSING AND REGULATORY AFFAIRS CUSTOMER DRIVEN. BUSINESS MINDED.

To look up your license renewal date, please visit: https://w2.lara.state.mi.us/VAL/License/Search

To renew your license, please visit: https://mylicense.mdch.state.mi.us/MyLicenseEnterpriseRen/Login.aspx

If you are audited and need clarification of the requirements, please contact MSMS or an experienced health care attorney, prior to communicating with LARA or the Board of Medicine.

MSMS offers online modules that fulfill the new CME requirements in the On-Demand Webinars section of the MSMS website.

For questions or more information, contact Brenda Marenich at bmarenich@msms.org or via phone at 517-336-7580.

SHARE YOUR NEWSWORTHY ITEMS

Have you or a MCMS colleague been elected to a position (specialty society, hospital, community based program, etc.) or honored for your volunteer service within the community or abroad? Let us know.

We would like to recognize MCMS members in the "Member News" section of the Medicus. Contact Heidi Leach at mcms@msms.org or macombcms@gmail.com with newsworthy information. *Publication is subject to availability of space and the discretion of the Editor.*

PROVIDERS MUST ENROLL IN MICHIGAN MEDICAID PROGRAM

Health care providers that serve Medicaid beneficiaries are facing an upcoming enrollment deadline that is necessary for them to continue to receive payments from Medicaid.

While the Michigan Department of Health and Human Services (MDHHS) has revised the timeline to give providers more time to enroll, the department is urging providers to complete the enrollment process as soon as possible.

For dates of service on or after Jan. 1, 2019, MDHHS will prohibit contracted Medicaid Health Plans and Dental Health Plans from making payments to typical providers not actively enrolled in Community Health Automated Medicaid Processing System (CHAMPS) -- the state's online Medicaid enrollment and billing system.

Typical providers are health care professionals that provide health care services to beneficiaries. They must meet education and state licensing requirements and have assigned National Provider Identifiers. Examples include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.

At this time, contracted Integrated Care Organizations (ICOs), Prepaid Inpatient Health Plans (PIHPs) and MI Choice Waiver agencies are exempt from this requirement. CHAMPS enrollment neither requires nor mandates providers in a managed care network to accept Fee-for-Service Medicaid beneficiaries. CHAMPS enrollment is used solely to screen providers participating in Medicaid.

For dates of service on or after July 1, 2019, MDHHS Fee-for-Service and Medicaid Health Plans will prohibit payment for prescription drug claims written by a prescriber who is not enrolled. More details on prescriber enrollment will be forthcoming early in 2019.

The federal Affordable Care Act and the 21st Century Cures Act require all providers who serve Medicaid beneficiaries to be screened and enrolled in the state Medicaid enrollment system. The purpose of this requirement is to protect beneficiaries by strengthening program integrity and care quality.

For information about the Provider Enrollment process and how to get started, please visit www.michigan.gov/MedicaidProviders and then click on "Provider Enrollment"

Providers also can learn more details by viewing future Provider Bulletins from MDHHS. Providers who have questions about the enrollment process or require assistance may contact the MDHHS Provider Enrollment Help Desk at 1-800-292-2550.

MSLRP APPLICATION PERIOD: FEBRUARY 4-8, 2019

The Michigan State Loan Repayment Program (MSLRP) assists employers in the recruitment and retention of medical, dental, and mental health primary care providers who continue to demonstrate their commitment to building long-term primary care practices in underserved communities designated as Health Professional Shortage Areas (HPSAs). MSLRP will assist those selected by providing up to $200,000 in tax-free funds to repay their educational debt over a period of up to eight years. Participants compete for consecutive two-year MSLRP agreements requiring them to remain employed for a minimum of 40 hours per week for no less than 45 weeks per year at eligible nonprofit practice sites providing primary healthcare services to ambulatory populations. Providers must remain with the employers who sponsor them during their two-year agreements, and employers must continue to employ the providers they sponsor during their two-year service obligations.

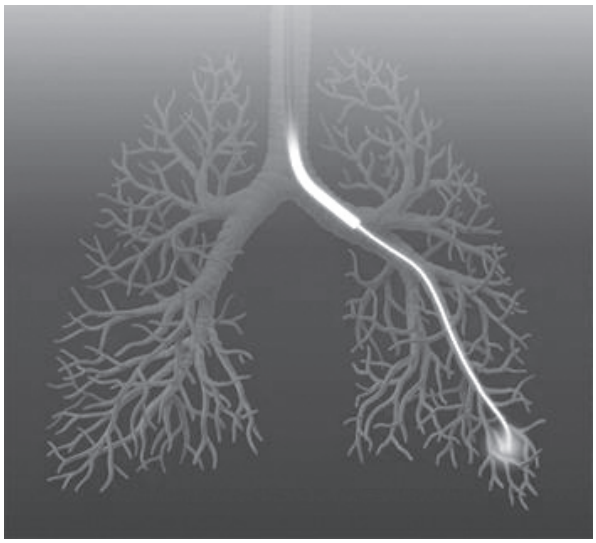
The MSLRP application process is very competitive. Providers and employers serious about successfully competing for a loan repayment agreement will need to carefully read the attached MSLRP Application Period Update, the entire MSLRP website at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_40012---,00.html, as it is updated for the current application period, including the Participant Information and Requirements sections, as well as the instructions on all required application forms.

Henry Ford Macomb Hospital

LUNG GPS TECHNOLOGY AIDS IN EARLIER DIAGNOSIS FOR LUNG LESIONS

Henry Ford Macomb Hospital now offers a minimally invasive procedure that may aid in earlier diagnosis for patients with lung lesions, so those with cancer can get treated as soon as possible and patients with benign conditions can potentially avoid surgery.

Electromagnetic Navigation Bronchoscopy procedures (ENB), which are performed with a device known as the Super Dimension navigation system with Lung GPS technology, allow physicians to navigate and access difficult-to-reach areas of the lung from the inside.



ENB is a recommended method of obtaining lung tissue biopsies from peripheral regions. This fluoroscopic navigation technology provides:

- Enhanced visualization of soft tissue objects like lung lesions.
- Accurate modeling of three-dimensional distances on two-dimensional images.
- Local registration to help compensate for local CT-to-body divergence - up to 3 cm.
- Updated catheter position relative to nodule, once nodule location is confirmed.
- Ability to visualize smaller nodules.

"Henry Ford Macomb is the second hospital in the state and the first of only a few dozen in the country to offer this technology to patients," said Dr. Raed Alnajjar, cardiothoracic surgeon. "This will help us to establish an Advanced Lung Center of Excellence at Henry Ford Macomb Hospital."

For referrals, contact Henry Ford Macomb Thoracic Surgery at (586) 263-2980.

CALENDAR CELEBRATES TRIUMPH OVER ADDICTION

Henry Ford Macomb Hospitals has partnered with CARE of Southeastern Michigan and Project Vox, a recovery advocacy group, to produce the 2019 Faces of Recovery calendar, which highlights the success of people in long term recovery from drug and alcohol addiction.

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

Approximately 5,500 copies of the 2018 calendar will be distributed throughout the metro Detroit area by CARE and various advocacy groups. Henry Ford Health System also makes the calendars available to Behavioral Health patients.

The goal of the calendar is to show individuals battling addiction that recovery is possible and to help remove the stigma that surrounds it.

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

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

About the partners

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

- Residential and outpatient substance abuse treatment for adults and adolescents.
- Outpatient programs, including detoxification and medication assisted treatment.
- Community Education and family support groups.

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

CARE of Southeastern Michigan

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

Greater Macomb Project Vox

The mission of Greater Macomb Project Vox is to unify the voice of the recovery community in order to reshape public attitudes

and eliminate the discrimination toward individuals who are living with an addiction to alcohol and other drugs. For more information, visit www.projectvox.com.

HENRY FORD MACOMB EARNS NATIONAL DIABETES RECOGNITION

Henry Ford Macomb Hospital has been nationally recognized for the quality of its diabetes prevention program.

The hospital is the first in Macomb County to earn "full recognition" from the Centers for Disease Control and Prevention, which awards the designation to organizations that "deliver quality, evidence-based" diabetes prevention programs. Organizations must also meet a series of criteria to qualify for recognition consideration.

Henry Ford Macomb is among 14 organizations statewide and 250 nationally to earn the designation. The diabetes prevention program is a partnership between the hospital and Henry Ford Macomb Faith Community Nursing Network.

"We are honored to achieve this CDC designation," says Henry Ford Macomb President and CEO Barbara Rossmann. "The prevalence of diabetes touches more people than we realize in Macomb County and beyond. The individuals who come through our program have access to a curriculum of classes and support proven to help them make sustainable lifestyle changes while improving their overall health."

Rossmann lauded the leadership efforts of Marian Giacona, RN, and Ameldia Brown, RN, who co-lead the program, for "making this designation possible." The designation is good for two years, after which Henry Ford Macomb would have to be reapply and undergo an evaluation.

Geared for patients diagnosed with prediabetes, the program seeks to reduce their risk of developing type 2 diabetes. More than 350 patients have enrolled in the program since its inception in 2015. On average, they have each lost 7 percent of their body weight.

Under Henry Ford Macomb's year-long program, patients diagnosed to have prediabetes meet with a trained lifestyle coach who offers advice and support for:

- Eating healthy.
- Adding physical activity to their daily routine.
- Dealing with stress.
- Staying motivated and overcoming barriers.

More than 84 million Americans are living with prediabetes - 2.6 million in Michigan alone - and nearly 90 percent of them don't know they have it and aren't aware of the long-term health risks. Prediabetes is a condition in which the blood glucose, or A1C levels, are higher than normal but not yet high enough to be considered type 2 diabetes.

A person with prediabetes is at increased risk for developing type 2 diabetes and other serious, long-term health issues such as heart attack and stroke. However, prediabetes can often be reversed through lifestyle changes like weight loss, healthy eating, and increased physical activity.

Programs recognized by the CDC are based on research led by the National Institutes of Health. This research shows that people with prediabetes who take part in a structured lifestyle change program reduce their risk of developing type 2 diabetes by 58 percent.

Long-term results are equally striking: participants are one-third less likely to develop type 2 diabetes 10 years after completing the program. Additionally, participants lose 5-7 percent of their body weight by eating healthier and engaging in 150 minutes of physical activity every week.

3 HOSPITALS EARN TOP HOSPITAL HONOR

Henry Ford Health System announced on December 3rd that three of its hospitals were named a Top Hospital for patient safety and quality by The Leapfrog Group.

It's the first time Henry Ford hospitals were jointly awarded the designation, which The Leapfrog Group issues annually. The hospitals are:

Henry Ford Hospital.

Henry Ford Macomb Hospital.

Henry Ford West Bloomfield Hospital.

"I'm so proud of our hospital leaders - Veronica Hall, RN, Barbara Rossmann and Lynn Torossian - and our physicians, nurses and entire hospital teams who demonstrate such pride and passion in taking care of our patients," says Bob Riney, president of Healthcare Operations and chief operating officer. "This honor reflects their relentless commitment and teamwork to deliver a high level of care in a safe, healing environment."

Henry Ford's hospitals were among 118 to earn the designation from nearly 1,900 hospitals nationally. The Top Hospital designation is determined by a methodology that measures hospital care performance across multiple areas including infection rates, maternity care, mortality and physician staffing in the intensive care unit.

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

"Congratulations to our hospital leaders and their teams for this achievement," says Adnan Munkarah, MD, executive vice president and chief clinical officer. "Each day we strive to uphold the highest standards of quality and safety, and these types of recognitions go a long way to validate our caregiving efforts."

In November, the three hospitals, along with Henry Ford Allegiance Health and Henry Ford Wyandotte Hospital, each received an A grade for patient safety performance in The Leapfrog Group's bi-annual safety grades.

Dr. Michael Trpkovski (holding scissors), with the radiology staff, cut the ribbon at a November Open House for Henry Ford Macomb's new Interventional Radiology suite.

Ascension Macomb-Oakland Hospital

ASCENSION MACOMB-OAKLAND HOSPITAL APPOINTS NEW CHIEF OF CARDIOLOGY

Ascension Macomb-Oakland Hospital has selected cardiologist Ted Schreiber, MD, as the chief of the hospital's Cardiology Service Line. The appointment was effective Dec. 1.

Dr. Schreiber is a respected leader and skilled cardiologist who has practiced interventional cardiology for more than 25 years at Ascension St. John Hospital, Ascension Macomb-Oakland Hospital and other metro Detroit systems. He has held leadership positions at other major health systems in metro Detroit and is a pioneer in complex treatments for higher risk cardiology patients. His work has also been published in medical journals, and he remains active in teaching and research.

Dr. Schreiber's reputation and standards for uncompromised quality are well-recognized throughout the medical community. His leadership and high standards, will be particularly useful as Ascension Macomb-Oakland finalizes its $48 million hospital expansion including a new inpatient unit for cardiology patients and new catheterization laboratory.

Board certified in cardiology, Dr. Schreiber received his medical degree from Cornell University Medical College and his internship and residency at the New York Hospital - Cornell Medical Center. He was a Clinical Fellow in Cardiology at the New York Hospital, and an Interventional Cardiology Fellow at William Beaumont Hospital.

Dr. Schreiber succeeds Dr. Lingareddy Devireddy, who will continue to see patients at his private practice at 11900 E. 12 Mile Road in Warren and at Ascension Macomb-Oakland Hospital. Dr. Devireddy has served Ascension Macomb-Oakland Hospital as chief for 19 years and was instrumental in the growth of cardiology services at the hospital. Under his leadership, the interventional cardiology program, cardiology and interventional cardiology fellowships and the open-heart surgery program at the hospital were established.

ASCENSION MACOMB-OAKLAND PRESIDENT HONORED AS HUMANITARIAN OF THE YEAR

Ascension Macomb-Oakland Hospital President Terry Hamilton received the Humanitarian of the Year Award from World Medical Relief (WMR) in recognition for his service to the organization. Terry is a board member of WMR.

Helping Terry celebrate are, l-r: Jeremy and Amanda Works, WMR President and CEO Dr. George Samson, Terry Hamilton, Josie Myles, Joanna McGuckin, Anne Marie Kaminski and Brian Kaminski.

Marihuana Became Legal in Michigan on December 6

At this time, Michigan is still evaluating the ballot language to determine its impact on the state. According to the U.S. Centers for Disease Control and Prevention, marihuana use may have a wide range of health effects on the body and brain.

Additionally, marihuana is still an illegal drug at the federal level.

Background

- On November 6, 2018, Michigan voters approved Proposal 1, creating the Michigan Regulation and Taxation of Marihuana Act.
- Among other things, this Act delegates responsibility for marijuana licensing, regulation and enforcement to the Michigan Department of Regulatory Affairs (LARA).
- LARA's Bureau of Medical Marihuana Regulation (BMMR) is responsible for the oversight of medical and recreational marihuana in Michigan.
- The Act requires LARA to start accepting license applications 12 months after the effective date of the Act.
- For licensing information, contact LARA BMMR Enforcement Section at 517-284-8597 or LARA-BMMR-Enforcement@michigan.gov
- Although the Act allows people to be in possession of certain amounts of marihuana for personal use, any form of sales requires a license from LARA. No amount of marihuana product can be sold without a license from LARA.

Food and Agriculture Impact

- A food establishment license issued by the Michigan Department of Agriculture and Rural Development does NOT allow operators to produce or sell marihuana or marihuana-infused products. Selling marihuana or marihuana infused products requires a license from LARA.
- The Cottage Foods exemption under the Michigan Food Law does not apply to marihuana infused products. You must be licensed by LARA to sell marihuana infused products. This includes any sales of marihuana or marihuana infused product sales at farmers markets or through online marketplaces.
- At this time, incorporating CBD oil or industrial hemp into food products is not allowed under the Act. While the Act separates industrial hemp from the definition of marihuana, that does not automatically make it acceptable to incorporate into food. Those substances are still illegal at the federal level and MDARD typically relies on the federal government to determine what is generally regarded as safe.

continued

Public Health and Marihuana

- According to the U.S. Centers for Disease Control and Prevention (CDC), marihuana is the most commonly used illegal drug in the United States, with 37.6 million users in the past year, and marihuana use may have a wide range of health effects on the body and brain.
- Like any other drug, marihuana's effects on a person depends on a number of factors, including the person's previous experience with the drug or other drugs, biology (e.g., genes), gender, how the drug is taken, and how strong it is.
- The marihuana plant has chemicals that may help symptoms for some health problems.
- More states, including Michigan, are making it legal to use the plant as medicine for certain conditions but there isn't enough research to show that the whole plant works to treat or cure these conditions.
- Also, the U.S. Food and Drug Administration (FDA) has not recognized or approved the marihuana plant as medicine.
- Because marihuana is often smoked, it can damage your lungs and cardiovascular system (e.g., heart and blood vessels). These and other damaging effects on the brain and body could make marihuana more harmful than helpful.
- Another problem with marihuana as a medicine is that the ingredients are not exactly the same from plant to plant. Right now, there's no way to know what kind and how much of a chemical you're getting.
- Two medicines have been made as pills from a chemical that's like THC, one of the chemicals found in the marihuana plant that makes people feel "high."
  - These two medicines can treat nausea if you have cancer and make you hungry if you have AIDS and don't feel like eating.
  - But the chemical used to make these medicines affects the brain also, so it can do things to your body other than just working as medicine.
- Another marihuana chemical that scientists are studying, called cannabidiol (CBD), doesn't make you high because it acts on different parts of the nervous system than THC.
  - Scientists think this chemical might help children who have a lot of seizures that can't be controlled with other medicines.
  - Some studies have begun to see whether it can help but more science is needed to determine if it is or not.

Proposal 1 Passage

- Under Proposal 1, personal use and possession of marihuana will be legal for those 21 and over. Personal use is defined as 2.5 ounces in possession, or up to 12 plants in a home for personal use.
- Commercial marihuana will be established following rules developed by the Michigan Department of Licensing and Regulatory Affairs (LARA). Municipalities can prohibit commercial businesses in their communities. The Ballot Proposal requires LARA to begin issuing licenses within 12 months of the passage of the act.
- This act also allows for the production of industrial hemp.
- This act does NOT authorize:
  - people to operate vehicles or other machinery under the influence of marihuana
  - butane extraction in residential property
  - possession in schools
  - consumption in a place prohibited by the property owner
  - consumption in public
  - marihuana edibles that can appeal to children
- Commercial sales of marihuana will be subject to a 10 percent tax. The revenue generated from this tax will be distributed as follows:
  - 15 percent to cities and townships
  - 15 percent to counties
  - 5 percent for the school aid fund
  - 35 percent for roads
- There are a number of implementation issues that must be worked out by the State of Michigan going forward. Some of these issues include:
  - Michigan's indoor smoking law does not protect against second hand marihuana smoke. Current law that prevents second-hand smoke is limited to tobacco. While public use is not authorized by the act, public use is likely to occur.
  - This act would prohibit legal use of marihuana from being the reason child custody or visitation are restricted unless they are creating an unreasonable danger for the child. This could potentially impact children services workers and cases.
  - In addition, there are likely to be questions about how legalized marihuana will impact the public health of all residents. There will need to be work done by the entire State of Michigan to gather more information as the act goes into effect.

Frequently Asked Questions

It's legal in many states, so doesn't that mean marihuana is safe?

The fact that it's legal does not mean that it is safe. Using marihuana at an early age can lead to negative health consequences.

Heavy marihuana use (daily or near-daily) can do damage to memory, learning, and attention, which can last a week or more after the last time someone used.

Using marihuana during pregnancy or while breastfeeding may harm the baby, just like alcohol or tobacco.

Marihuana use has been linked to anxiety, depression, and schizophrenia, but scientists don't yet know whether it directly causes these diseases.

Smoking any product, including marihuana, can damage your lungs and cardiovascular system.

Is it possible for someone to become addicted to marihuana?

Yes, about 1 in 10 marihuana users will become addicted. For people who begin using younger than 18, that number rises to 1 in 6. For more information visit CDC's section on addiction or the National Institute on Drug Abuse's pages on addiction science.

Is it possible to "overdose" or have a "bad reaction" to marihuana?

A fatal overdose is unlikely, but that doesn't mean marihuana is harmless. The signs of using too much marihuana are similar to the typical effects of using marihuana but more severe. These signs may include extreme confusion, anxiety, paranoia, panic, fast heart rate, delusions or hallucinations, increased blood pressure, and severe nausea or vomiting. In some cases, these reactions can lead to unintentional injury such as a motor vehicle crash, fall, or poisoning.

Does marihuana use lead to other drug use?

The majority of people who use marihuana do not go on to use other, "harder" substances. More research is needed to understand if marihuana is a "gateway drug" - a drug that is thought to lead to the use of more dangerous drugs (such as cocaine or heroin).

What are the effects of mixing marihuana with alcohol, tobacco or prescription drugs?

Using alcohol and marihuana at the same time is likely to result in greater impairment than when using either one alone. Using marihuana and tobacco at the same time may also lead to increased exposure to harmful chemicals, causing greater risks to the lungs, and the cardiovascular system. Also, be aware that marihuana may change how prescription drugs work. Always talk with your doctor about any medications you are taking or thinking about taking and possible side effects when mixed with other things like marihuana.

How harmful is K2/Spice (synthetic marihuana or synthetic cannabinoids)?

Synthetic cannabinoids (e.g., synthetic marihuana, K2, Spice, Spike) -- or plants sprayed with unknown chemicals -- are dangerous and unpredictable. Synthetic cannabinoids are not marihuana, but like THC, they bind to the same cannabinoid receptors in the brain and other organs. Synthetic cannabinoids are also illegal in Michigan.

Research shows that synthetic cannabinoids affect the brain much more powerfully than marihuana creating unpredictable and, in some cases, life-threatening effects including nausea, anxiety, paranoia, brain swelling, seizures, hallucinations, aggression,

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!

heart palpitations, and chest pains. For additional questions around synthetic cannabinoids, visit CDC's National Center for Environmental Health page on synthetic marihuana or the National Institute on Drug Abuse page on synthetic marihuana.

Is it safe for a breastfeeding mom to use marihuana?

We do not yet know. Chemicals from marihuana can be passed to your baby through breast milk. THC is stored in fat and is slowly released over time, meaning that your baby could still be exposed even after you stop using marihuana. However, data on the effects of marihuana exposure to the infant or baby through breastfeeding are limited and conflicting. To limit potential risk to the infant, breastfeeding mothers should reduce or avoid marihuana use.

Can secondhand marihuana smoke affect nonsmokers, including children?

Secondhand marihuana smoke contains tetrahydrocannabinol (THC), the chemical responsible for most of marihuana's psychological effects, and many of the same toxic chemicals in smoked tobacco.

Smoked marihuana has many of the same cancer-causing substances as smoked tobacco, but there are still a lot of unanswered questions around secondhand marihuana smoke exposure and its impact on chronic diseases such as heart disease, cancer, and lung diseases.

How is eating and drinking foods that contain marihuana (edibles) different from smoking marihuana?

Because marihuana contains tetrahydrocannabinol (THC), there are health risks associated with using marihuana regardless of the how it is used. Some of these negative effects include having difficulty thinking and problem-solving, having problems with memory, learning and maintaining attention and demonstrating impaired coordination. Additionally, frequent use can lead to becoming addicted to marihuana. However, some risks may differ by the way it is used.

Smoke from marihuana contains many of the same toxins, irritants, and carcinogens as tobacco smoke. Smoking marihuana can lead to a greater risk of bronchitis, cough, and phlegm production. Whereas, edibles, which take longer to digest, take longer to produce an effect. Therefore, people may consume more to feel the effects faster. This may lead to people consuming very high doses and result in negative effects like anxiety, paranoia and, in rare cases, an extreme psychotic reaction (e.g. delusions, hallucinations, talking incoherently, and agitation).

Specific Marihuana and Health Detail (direct from the CDC)

ADDICTION

About 1 in 10 marihuana users will become addicted. For people who begin using before the age of 18, that number rises to 1 in 6.

People who are addicted to marihuana may also be at a higher risk of other negative consequences of using the drug, such as problems with attention, memory, and learning. Some people who are addicted need to smoke more and more marihuana to get the same high. It is also important to be aware that the amount of tetrahydrocannabinol (THC) in marihuana (i.e., marihuana potency or strength) has increased over the past few decades. The higher the THC content, the stronger the effects on the brain. In addition, some methods of using marihuana (e.g., dabbing, edibles) may deliver very high levels of THC to the user. Researchers do not yet know the full extent of the consequences when the body and brain (especially the developing brain) are exposed to high concentrations of THC or how recent increases in potency affect the risk of someone becoming addicted.

BRAIN HEALTH

Marihuana use directly affects the brain -- specifically the parts of the brain responsible for memory, learning, attention, decision making, coordination, emotions, and reaction time.

Heavy users of marihuana can have short-term problems with attention, memory, and learning, which can affect relationships and mood.

Marihuana also affects brain development. When marihuana users begin using as teenagers, the drug may reduce attention, memory, and learning functions and affect how the brain builds connections between the areas necessary for these functions.

Marihuana's effects on these abilities may last a long time or even be permanent. This means that someone who uses marihuana may not do as well in school and may have trouble remembering things.

The impact depends on many factors and is different for each person. It also depends on the amount of tetrahydrocannabinol (THC) in marihuana (i.e., marihuana potency or strength), how often it is used, the age of first use, and whether other substances (e.g., tobacco and alcohol) are used at the same time.

Developing brains, like those in babies, children, and teenagers are especially susceptible to the hurtful effects of marihuana. Although scientists are still learning about these effects of marihuana on the developing brain, studies show that marihuana use by mothers during pregnancy may be linked to problems with attention, memory, problem-solving skills, and behavior problems in their children.

CANCER

Cannabinoids are the active chemicals in marihuana that cause drug-like effects throughout the body, including the central nervous system and the immune system. The main active cannabinoid in marihuana is delta-9-THC. Another active cannabinoid is cannabidiol (CBD), which may relieve pain and lower inflammation without causing the "high" of delta-9-THC. Although marihuana and cannabinoids have been studied with respect to managing side effects of cancer and cancer therapies, there are no ongoing clinical trials of marihuana or cannabinoids in treating cancer in people. Studies so far have not shown that cannabinoids help control or cure the disease. And like many other drugs, marihuana can cause side effects and complications.

Relying on marihuana alone as treatment or for managing side effects while avoiding or delaying conventional medical care for cancer may have serious health consequences.

Studies of man-made forms of the chemicals found in the marihuana plant can be helpful in treating nausea and vomiting from cancer chemotherapy. Studies have found that marihuana can be helpful in treating neuropathic pain (pain caused by damaged nerves).

At this time, there is not enough evidence to recommend that patients inhale or ingest marihuana as a treatment for cancer-related symptoms or side effects of cancer therapy.

Smoked marihuana delivers THC and other cannabinoids to the body, but it also delivers harmful substances to users and those close by, including many of the same substances found in tobacco smoke, which are harmful to the lungs and cardiovascular system.

Researchers have found limited evidence of an association between current, frequent, or chronic marihuana smoking and testicular cancer (non-seminoma-type).

Because marihuana plants come in different strains with different levels of active chemicals, it can make each user's experience very hard to predict. More research is needed to understand the full impact of marihuana use on cancer.

CHRONIC PAIN

Even though pain management is one of the most common reasons people use medical marihuana in the U.S., there is limited evidence that marihuana works to treat most types of chronic pain.

A few studies have found that marihuana can be helpful in treating neuropathic pain (pain caused by damaged nerves). However, more research is needed to know if marihuana is any better or any worse than other options for managing chronic pain.

HEART HEALTH

Using marihuana makes the heart beat faster. It could also lead to increased risk of stroke and heart disease. However, most of the scientific studies linking marihuana to heart attacks and strokes are based on reports from people who smoked it. Smoked marihuana delivers THC and other cannabinoids to the body, but it also delivers harmful substances to users and those close by, including many of the same substances found in tobacco smoke, which are harmful to the lungs and cardiovascular system. So it's hard to separate the effects of the compounds in marihuana on the cardiovascular system from the hazards posed by the irritants and other chemicals contained in the smoke. More research is needed to understand the full impact of marihuana use on the circulatory system to determine if marihuana use leads to higher risk of death from these causes.

LUNG HEALTH

How marihuana affects lung health is determined by how it's consumed. In many cases, marihuana is smoked in the form hand-rolled cigarettes (joints), in pipes or water pipes (bongs), in bowls, or in blunts -- emptied cigars that have been partly or completely refilled with marihuana. Smoked marihuana, in any form, can harm lung tissues and cause scarring and damage to small blood vessels. Smoke from marihuana contains many of the same toxins, irritants, and carcinogens as tobacco smoke. Smoking marihuana can also lead to a greater risk of bronchitis, cough, and phlegm production. These symptoms generally improve when marihuana smokers quit.

The known health risks of secondhand exposure to cigarette smoke -- to the heart or lungs, for instance -- raise questions about whether secondhand exposure to marihuana smoke poses similar health risks.

While there is very little data on the health consequences of breathing secondhand marihuana smoke, there is concern that it could cause harmful health effects, including among children.

Recent studies have found strong associations between those who said there was someone in the home who used marihuana or a caretaker who used marihuana and the child having detectable levels of THC -- the psychoactive ingredient in marihuana. Children exposed to the psychoactive compounds in marihuana are potentially at risk for negative health effects, including developmental problems for babies whose mothers used marihuana while pregnant. Other research shows that marihuana

use during adolescence can impact the developing teenage brain and cause problems with attention, motivation, and memory.

MENTAL HEALTH

Marihuana use, especially frequent (daily or near daily) use and use in high doses, can cause disorientation, and sometimes cause unpleasant thoughts or feelings of anxiety and paranoia.

Marihuana users are significantly more likely than nonusers to develop temporary psychosis (not knowing what is real, hallucinations and paranoia) and long-lasting mental disorders, including schizophrenia (a type of mental illness where people might see or hear things that aren't really there). Marihuana use has also been linked to depression and anxiety, and suicide among teens. However, it is not known whether this is a causal relationship or simply an association.

POISONING

Edibles, or food and drink products infused with marihuana and eaten, have some different risks than smoking marihuana, including a greater risk of poisoning. Unlike smoked marihuana, edibles can:

- Take from 30 minutes to 2 hours to take effect. Some people eat too much, which can lead to poisoning and/or serious injury.
- Cause effects that last longer than expected depending on the amount, the last food eaten, and medications or alcohol used at the same time.
- Be very difficult to measure. The amount of THC, the active ingredient in marihuana, is very difficult to measure and is often unknown in edible products. Many users can be caught off-guard by the strength and long-lasting effects of edibles.

It is also important to remember that marihuana affects children differently than adults. Since marihuana has become legal in some states, children have accidentally eaten marihuana products that looked like candy and treats, which made them sick enough to need emergency medical care. If you use marihuana products, keep them in childproof containers and out of the reach of children. For additional questions, you can contact your health care provider, your health department, the Poison Helpline at 1-800-222-1222, or 911 if it's an emergency.

RISK OF USING OTHER DRUGS

The concept of marihuana as a "gateway drug" -- where using marihuana leads a person to use other drugs -- generates a lot of disagreement. Researchers haven't found a definite answer yet. However, most people who use marihuana do not go on to use other, "harder" drugs.

It is important to remember that people of any age, sex, or economic status can become addicted to marihuana or other drugs. Things that can affect the likelihood of substance use include:

- Family history.
- Having another mental health illness (such as anxiety or depression).
- Peer pressure.
- Loneliness or social isolation.
- Lack of family involvement.
- Drug availability.
- Socioeconomic status.

DECEMBER 5, 2018 MCMS ANNUAL MEMBERSHIP MEETING & HEALTH SYSTEMS UPDATE

The Macomb County Medical Society held its Annual Meeting on Wednesday, December 5 at Ike's Restaurant in Sterling Heights. Our guest speakers were Barbara Rossmann, President & CEO of Henry Ford Macomb Hospital and Terry Hamilton, President of Ascension Macomb-Oakland Hospital. Both administrators gave in-depth presentations on the current activities at their respective hospitals and discussed the future of medicine in Macomb County.

Following the Health Systems Update, MCMS Board Member Lawrence Handler, MD presented a plaque of appreciation to outgoing MCMS President Dan Ryan, MD for his service to the society this past year.

Thanks to Your Generosity the 2018 Holiday Sharing Card Project Raised $5,230

We would like to thank the MCMS members who participated in this years MCMS Foundation Holiday Sharing Card Project. Due to your generous donations we were able to raise $2,415 for the Macomb County Food Program and $2,815 for Turning Point Shelter for women.

EXTORTION SCAM TARGETING DEA REGISTRANTS

The Drug Enforcement Administration (DEA) has learned that registrants are receiving telephone calls and emails by criminals identifying themselves as DEA employees or other law enforcement personnel. The criminals have masked their telephone number on caller ID by showing the DEA Registration Support 1-800 number. A DEA employee would not contact a registrant and demand money or threaten to suspend a registrant's DEA registration. Physicians who are contacted by a person purporting to work for DEA and seeking money or threatening to suspend their DEA registration can submit information through the DEA Diversion Control Division's "Extortion Scam Online Reporting" webpage, www.DEADiversion.usdoj.gov.

For information contact:

Detroit DEA Field Office -
313-234 4028 or 313-234-4202
Email -
Detroit.Diversion.Registration@Usdoj.Gov

Registration Service Center -
1-800-882-9539
Email -
DEA.Registration.Help@usdoj.gov

CMS MOVES ON E/M: 3 THINGS PHYSICIANS SHOULD KNOW

There were major victories for physicians in the 2019 Medicare physician fee schedule final rule, particularly when it comes to payment for evaluation-and-management (E/M) services. But with the document running nearly 2,400 pages, it could be difficult to sort them out. So here are three things physicians need to know about next year's fee schedule from the Centers for Medicare & Medicaid Services (CMS).

1. CMS has postponed the E/M coding "collapse" for at least two years. CMS will postpone its proposal to collapse payment rates for four E/M office visit services into a single blended rate. The AMA advised CMS that the proposal could create unintended consequences for specialties that treat the sickest patients and for physicians who provide comprehensive primary care. In revising E/M payments, CMS also announced it would take into consideration the recommendations of the AMA-convened Current Procedural Terminology (CPT®)/Relative Value Scale Update Committee (RUC) Workgroup. The group has already held five conference calls and one in-person meeting.

More than 200 individuals have participated in each meeting, including CMS staff, medical officers and contractors.

The workgroup has used a formal survey mechanism to solicited feedback throughout the process to ensure that maximum input is acquired to achieve consensus. More than 60 national specialty societies have responded to these surveys.

"The panel members have deep expertise in defining and valuing codes, and as members of various specialties, they all use the office visit codes to describe and bill for services provided to Medicare patients," said AMA President Barbara L. McAneny, MD. "The group is analyzing these issues and plans to offer solutions to be provided to CMS for future implementation."

The workgroup is also working to build consensus around modernizing the office and outpatient E/M CPT codes to simplify the documentation requirements and better focus code selection around medical decision-making and physician time. "The two-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders," CMS said in the final rule. "We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes, through our annual rulemaking process."

2. Proposed same-day-service pay cut will not be implemented. CMS has dropped its proposal to chop in half payments for office visits that occur on the same day as a procedure furnished by the same physician or another physician in the same practice. Also dropped from consideration is a proposal to create a new indirect practice expense category for office visits. This proposal would have resulted in large changes in payments for some specialties - including a greater than 10 percent pay cut for chemotherapy services.

3. New documentation rules cut physician administrative burden. CMS followed suggestions provided by the AMA and some 170 other medical groups in a letter sent to CMS Administrator Seema Verma. Specifically, physicians will not have to redocument elements of a patient's medical history and physical exam. Instead, documentation will focus on patients' medical history during the interval since the previous visit. Also gone is a requirement that physicians redocument information recorded by their staff or by the patient. In addition, a requirement to document the medical necessity of furnishing a home visit rather than an office visit has been eliminated.

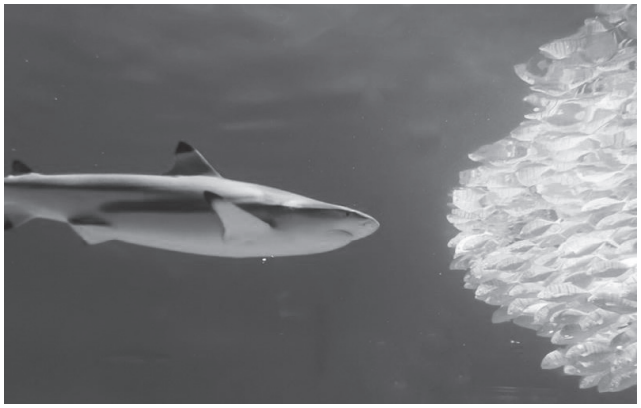
"With physicians facing excessive documentation requirements in their practices, it is a relief to see that the administration not only understands the problem of regulatory burden but is taking concrete steps to address it," Dr. McAneny said. "Patients are likely to see the effect as their physicians will have more time to spend with them and be able to more quickly locate relevant information in medical records."

MOST COMMERCIAL HEALTH INSURANCE MARKETS ARE HIGHLY CONCENTRATED

By: Andis Robeznieks, Senior News Writer

Research from the AMA shows that half of all states had commercial health insurance markets that were less competitive in 2017 than during the previous year.

"The AMA continues to urge that competition, not consolidation, is the right prescription for health insurance markets," said AMA President Barbara L. McAneny, MD. "The slide toward insurance monopolies has created a market imbalance that disadvantages patients and favors powerful health insurers."



The 2018 update to Competition in Health Insurance: A Comprehensive Study of U.S. Markets presents 2017 data on the degree of competition in health insurance markets and identifies where consolidation may cause competitive harm to patients and physicians.

Concentrated markets squeeze doctors

The study examines market share and concentration data for 50 states, the District of Columbia, and 380 metropolitan statistical areas (MSAs). Researchers found that the majority of U.S. commercial health insurance markets are highly concentrated and thus ripe for the exercise of health insurer market power that harms patients and physicians.

That exercise of market power leads to higher premiums for patients, lower payments to physicians, and fewer people with coverage than in a competitive market. The study's data is based on commercial enrollment in HMO, PPO, POS and public exchange plans, including participation in consumer-driven health plans.

To gauge market concentration, the researchers used the Herfindahl-Hirschman Index (HHI), a measure used by the Justice Department and the Federal Trade Commission as an indicator of market competition. Smaller numbers indicate greater competition. An HHI of 10,000 indicates a monopoly.

In 91 percent of MSAs, at least one insurer had a commercial market share of 30 percent or greater. The study says that in 46 percent of MSAs, a single insurer controlled at least half of the market. Other notable findings include:

- In 2016 and 2017, Anthem had the highest market share in more MSAs than any other insurer. Almost three-quarters of commercial markets are highly concentrated (HHI is greater than 2,500).
- The average HHI in commercial markets was 3,464, and the median HHI was 3,199.
- States with the largest decrease in competition levels between 2016 and 2017 are North Dakota, Alaska and Louisiana.
- States with the least competitive commercial health insurance markets are Alabama, Hawaii and Louisiana.

In fact, Alabama has an HHI of 7,194 with Blue Cross and Blue Shield of Alabama holding an 84 percent statewide market share. The Tuscaloosa, Alabama, MSA market has an 8,355 HHI, with Blue Cross and Blue Shield of Alabama holding a 91 percent market share.

Patients don't see benefits

Despite insurance company predictions to the contrary, industry consolidation has resulted in the possession and exercise of health insurer monopoly power - the ability to raise and maintain premiums above competitive levels - instead of their passing on purported efficiency benefits to consumers.

"The prospect of future mergers involving health insurance companies should raise serious antitrust concerns," Dr. McAneny said. "There is already too little competition among insurers, to the detriment of patients. Networks are already too narrow, and premiums are already too high."

The AMA led a coalition of 17 state medical societies and marshaled nationally recognized economic and legal experts to block the proposed Anthem-Cigna and Aetna-Humana megamergers that fell apart in 2017. Blocking the Anthem-Cigna deal averted an estimated $500 million in lower annual payments to physicians.

The AMA also worked to block the proposed CVS-Aetna merger. While the Justice Department's requirement that Aetna divest its Medicare Part D drug plan business was welcomed, the AMA expressed disappointment that the deal was allowed to move forward.

SOCIAL MEDIA GUIDANCE FOR PHYSICIANS TAPS TIMELESS PRINCIPLES

Social media has come a long way since Friendster, permeating every facet of American life - and medicine is no exception. If the decade and a half since Facebook was launched seems like an eternity on the social media timeline, it is but a blip for a guide to physician conduct that debuted more than 150 years ago.

Yet that guide, the AMA Code of Medical Ethics, has quite a bit to say about how physicians should navigate Instagram, Twitter, Snapchat and more. Learn how to apply the enduring principles of medical ethics to the quickly moving world of social media.

The Code recognizes both the attraction of social media and the special need for caution when physicians use it.

"Participating in social networking and other similar opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunities to widely disseminate public health messages and other health communication," notes the preamble to Opinion, 2.3.2, "Professionalism in the Use of Social Media."

"Social networks, blogs and other forms of communication online also create new challenges to the patient-physician relationship," the Code of Medical Ethics says.

Physicians widely - and, most often, wisely - use social media. It has also been misused, including shared images and other violations of patient privacy, as well as emails and texts that never should have been sent.

CEJA cited three of the nine Principles of Medical Ethics in rendering its opinion on physician use of social media. Those principles include respect for human dignity and rights, honesty and upholding the standards of professionalism, and the duty to safeguard patient confidences and privacy.

The opinion states:

Physicians should weigh a number of considerations when maintaining a presence online:

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

(b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.

(c) When using the internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the internet, content is likely there permanently.

Thus, physicians should routinely monitor their own internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

(d) If they interact with patients on the internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethics guidance just as they would in any other context.

(e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(f) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions.

If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students) and can undermine public trust in the medical profession.

A central theme of the guidance in Opinion 2.3.2 has to do with understanding and maintaining boundaries.

The AMA offers a credit-eligible CME course, Boundaries for Physicians: The Code of Medical Ethics, "to help physicians identify and understand how to maintain proper boundaries with their patients and to articulate and understand the underlying importance of those boundaries to the practice of medicine." The module is free to members ($20 for non-embers) and covers a wide range of situations, including social media.

2019 MSMS Legislative *Priorities*

The following are the legislative issues we are prioritizing in 2019. The majority of our resources and efforts will be dedicated to action on these issues.

PRIOR AUTHORIZATION REFORM

The prior authorization process diverts valuable resources away from direct patient care, can delay the start or continuation of necessary treatment and can negatively impact patient health outcomes. MSMS will work closely with the legislature, regulators and stakeholders on ways to streamline, standardize and make the prior authorization process more transparent and evidence-based.

Policy objective: Reform prior authorization with a focus on clinical validity, continuity of care, transparency and fairness; and timely access and administrative efficiency

Action: Advocate for legislation to reform prior authorization, including efforts that promote transparency and timely processing of requests.

ADDRESSING SUBSTANCE ABUSE IN MICHIGAN

In late 2017, Michigan passed a series of opioid laws in an effort to address the state's opioid epidemic. Several unintended consequences emerged as the laws took effect, some of which could negatively impact patient care and access to legitimate pain medication. Moreover, the laws failed to adequately address barriers to treatment.

The rise of prescription drug abuse is a growing concern among the physician community, however, it is important that solutions do not have the unintended consequence of denying access to pain patients. MSMS will be working to pursue solutions that focus on all areas of illicit prescription drug use, not just the interaction between the patient and the physicians.

On November 6, 2018, Michigan voters approved a ballot initiative making recreational marijuana use legal in Michigan. In the face of changing societal attitudes and relaxing state and local policy, the need to raise awareness around the dangers associated with the normalization of marijuana use has never been greater. MSMS will seek to partner with lawmakers, state regulators and other stakeholders to ensure the proper laws, rules and regulations are in place to protect the public.

Policy objectives: 1)Reduce opioid overdose deaths in Michigan by preserving patient access to legitimate pain medication and safeguarding the physician's ability to make sound clinical judgments in response to a patient's unique circumstances, while at the same time reducing prescription drug diversion and expanding access to treatment for opioid addiction.

2) Reduce the negative public health impacts of recreational marijuana in Michigan, particularly among the adolescent population.

Action: 1) advocate for legislative modifications to Michigan's new opioid laws that help assuage prescriber/patient angst and confusion, while still meeting the intent of reducing opioid-related deaths; 2) advocate for legislation to expand access to evidence-based, non-opioid therapies and evidence-based treatment for opioid addiction; and 3) advocate for legislative changes that, at the very least, provide clarification around issues, including any conflicts with our existing smoke free air laws and other public health safeguards.

GRADUATE MEDICAL EDUCATION (GME)

Studies repeatedly demonstrate that one of the best ways to recruit and retain physicians is via local medical schools and residency programs. GME helps fill the gap in under-served areas by providing extremely low-cost care to those most in need. Michigan has been a leader in expanding medical school class sizes to address the projected demand for physician services, it is imperative that we continue to fund GME slots to allow these future physicians to learn here in Michigan, train here in Michigan, and stay here in Michigan.

Policy objective: Recruit and retain medical talent in Michigan through an emphasis on GME funding models that appropriately reflect the health care needs of the state.

Action: Advocate for state funding for innovative initiatives,

like MIDOCS, which seek to place high need specialties in underserved areas of the state.

AUTO NO-FAULT REFORM

Michigan has been a leader in providing care to those injured in auto accidents by virtue of our no-fault statute. For 40 years, Michigan has required drivers to purchase coverage in the unfortunate event of a catastrophic injury. Unlike other states that burden taxpayers by allowing the injured to be shifted to the Medicaid program or increase uncompensated load on physicians and facilities. That said, reforms to the current system are needed. MSMS will continue to work with its partners in the Coalition for Protecting Auto No-Fault (CPAN) on reforms that bring fairness to insurance rates, increase transparency, crack down on fraud, reduce lawsuits and lower health care prices for accident victims.

Policy objective: Pursue reform that emphasizes the responsibility and accountability on the part of physicians and other health providers as well as insurance companies, assuring that the promise of no-fault remains for future generations.

Action: Advocate for the Fair and Affordable Auto No-Fault insurance plan and oppose efforts to implement a pure tort liability system.

TEAM-BASED CARE/SCOPE OF PRACTICE

Patients are best served by a team-based approach that provides the maximum amount of choice for their care while ensuring that they benefit from the additional training and expertise having a physician on the team. A highly functioning health care team is the best way to serve patients while addressing the other access issues, not legislation that creates silos. MSMS will continue to promote the role of the physician as the leader of the health care team and oppose any efforts to expand allied health professionals scope of practice that may put patients at risk.

Policy objective: Protect the health and safety of patients by opposing efforts of health care practitioners to seek licensure or recognition to perform tasks or procedures for which they lack the education, training or experience.

Action: Proactively promote physician-led, team-based care efforts, including holistic approaches to scope of practice and licensure that meaningfully address to care.

2019 MSMS LEGISLATIVE ACTION AGENDA

- These specific items align with MSMS's legislative priorities. The majority of our resources and efforts will be dedicated to the following action items:
- Advocate for legislation to reform prior authorization, including efforts that promote transparency and timely processing of requests.
- Advocate for modifications to Michigan's new opioid laws that help assuage prescriber/patient angst and confusion, while still meeting the intent of reducing opioid-related deaths.
- Advocate for expanded access to evidence-based, non-opioid therapies and evidence-based treatment for opioid addiction.
- Pursue legislation that makes maintenance of certification voluntary.
- Advocate for state funding for innovative healthcare workforce initiatives, like MIDOCs, which seek to place high need specialties in underserved areas of the state.
- Advocate for the Fair and Affordable Auto No-Fault insurance plan and oppose efforts to impose a pure tort liability system.
- Proactively promote physician-led, team-based care legislative and regulatory efforts, including holistic approaches to scope of practice and licensure that meaningfully address to care.
- Oppose unfunded mandates that could -- through additional financial or administrative hurdles -- undermine physicians' ability to care for patients.

STRATEGIES FOR ACCOMPLISHING ACTION AGENDA

1. Work closely with county medical societies, physician specialty societies, stakeholder groups and other partners to promote legislative agenda
2. Facilitate workgroup on prior authorization
3. Facilitate physician lobbyist meetings
4. Organize New Lawmaker reception in early 2019
5. Meet regularly with lawmakers and staff to foster relationships, particularly leadership and health policy committees
6. Prioritize grassroots engagement, including
   - Lansing Lobby Days
   - Doctor of the Day
   - Very Influential Physician (VIP) Advocate Program
   - In-district "Coffee Hour" lobby day
7. Align MDPAC fundraising strategy with MSMS legislative agenda
8. Promote member usage of Engage website, including Action Center
9. Deploy targeted and meaningful Action Alerts to engage physician members on issues
10. Provide regular legislative updates to membership and county medical societies

Health Department

Macomb County Health Department

Reportable Diseases Summary

Diseases Reported in Macomb County Residents*

Cumulative total for previous years; year-to-date total for November, 2018

	2018	2017	2016	2015	2014
AMEBIASIS	0	0	1	0	1
BLASTOMYCOSIS	1	0	1	0	1
BOTULISM (FOODBORNE)	0	0	0	0	0
BOTULISM (INFANT)	0	0	0	0	0
BRUCELLOSIS	0	0	0	0	0
CAMPYLOBACTER	112	120	96	79	86
CHICKENPOX	36	31	33	32	88
CHLAMYDIA	3,341	3,598	3,185	2,736	2,474
COCCIDIOIDOMYCOSIS	4	2	2	2	7
CREUTZFELDT JAKOB	1	2	2	2	2
CRYPTOCOCCOSIS	3	1	1	1	2
CRYPTOSPORIDIOSIS	12	6	10	1	9
CYCLOSPORIASIS	1	12	2	0	1
DENGUE FEVER	0	0	1	1	0
DIPHTHERIA	0	0	0	0	0
EHRLICHIOSIS	0	0	3	0	1
ENCEPHALITIS PRIMARY	2	4	1	2	3
ENC POST OTHER	2	1	1	1	2
FLU-LIKE DISEASE	20,133	28,172	21,747	27,943	28,824
GIARDIASIS	9	20	23	17	21
GONORRHEA	1020	946	801	522	477
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	9	9	10	4	6
HEMOLYTIC UREMIC SYN.	0	0	0	0	0
HEPATITIS A	31	201	9	5	4
HEPATITIS B (ACUTE)	4	5	9	6	7
HEP B (CHRONIC)	97	108	110	125	136
HEPATITIS C (ACUTE)	29	49	31	16	15
HEP C (CHRONIC)	795	898	931	673	693
HEPATITIS D	1	0	0	0	0
HEPATITIS E	1	0	0	0	0
H. FLU INVASIVE DISEASE	7	21	14	11	9
HISTOPLASMOSIS	3	0	5	5	2
HIV^	71	69	57	64	55
INFLUENZA	7,306	4,136	2,164	1,143	831
KAWASAKI SYNDROME	3	5	5	10	5

	2018	2017	2016	2015	2014
LEGIONELLOSIS	96	56	34	25	24
LISTERIOSIS	2	3	1	1	1
LYME DISEASE	8	5	3	5	1
MALARIA	2	2	2	2	1
MEASLES	0	1	0	0	0
MENINGITIS VIRAL	52	44	43	60	44
MENINGITIS BACTERIAL/BACTEREMIA *(EXCLUDING N. MENINGITIDIS)*	15	11	9	10	8
MENINGOCOCCAL DISEASE	0	0	1	1	1
MUMPS	1	3	2	0	2
PERTUSSIS	45	81	37	35	83
POLIO	0	0	0	0	0
PSITTACOSIS	0	0	0	0	0
Q FEVER	0	0	0	0	0
RABIES ANIMAL	4	2	1	1	3
RABIES HUMAN	0	0	0	0	0
REYE SYNDROME	0	0	0	0	0
ROCKY MNTN SPOTTED FVR	2	0	1	0	0
RUBELLA	0	0	0	0	0
SALMONELLOSIS	72	75	78	82	75
SHIGELLOSIS	8	46	50	22	9
STEC**	23	10	7	9	11
STREP DIS, INV, GRP A	42	32	31	27	26
STREP PNEUMO, INV + DR	49	45	55	52	45
SYPHILIS	123	84	79	108	77
SYPHILIS CONGENITAL	0	1	0	2	0
TETANUS	0	0	0	0	0
TOXIC SHOCK SYNDROME	1	0	0	1	1
TUBERCULOSIS	3	10	11	6	11
TULAREMIA	0	0	0	0	0
TYPHOID FEVER	0	0	0	1	1
VIBRIOSIS	2	0	1	0	0
VISA	0	1	0	0	1
WEST NILE VIRUS	11	7	2	4	0
YELLOW FEVER	0	0	0	0	0
ZIKA	0	0	4	0	0

*Includes both Probable and Confirmed case reports.

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

17-Dec-18

^ Previously reported as "AIDS"

MSMS
MICHIGAN STATE MEDICAL SOCIETY

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MCMS
Macomb County Medical Society
PO Box 551 • Lexington, MI 48450-0551
Macombcms@gmail.com • www.macombcms.org
Toll Free 877-264-6592

State & County Medical Society Membership Application

Member Status:

□ 1st Year of Practice Post-Residency □ 2nd Year of Practice Post-Residency □ 3rd year of Practice Post Residency
□ I have moved into Michigan, and this is my first year practicing in this state □ I work 20 hours or less per week
□ I am currently in active military duty □ I am in full-active practice
□ Male □ Female

First Name:_____ Middle:_____ Last Name:_____ MD or DO

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

Job Title: _____

Work Phone: _____ Work Fax:_____ Home Phone _____

Cell:_____ **Email:** _____

Office Address: □ Preferred Mail □ Preferred Bill □ Preferred Mail and Bill

Practice Name: _____

Street: _____

City:_____State:_____Zip:_____

Home Address: □ Preferred Mail □ Preferred Bill □ Preferred Mail and Bill

Street:_____

City:_____State:_____Zip:_____

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

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

License held in other states or countries: _____

Medical School: _____Graduation Year:_____ ECFMG# _____

Residency Program: _____Program Completion Year: _____

Fellowship Program: _____Program Completion Year: _____

Hospital Affiliation(s):_____

Primary Specialty: _____Board Certified □ Yes □ No Year_____

Secondary Specialty: _____Board Certified □ Yes □ No Year _____

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

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

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

Within the last five years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?:

□ Yes □ No If "yes", please provide full information on a separate sheet.

Within the last five years, have you been the subject of any disciplinary action by any medical society or hospital staff?:

□ Yes □ No If "yes", please provide full information on a separate sheet.

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

County Medical Society Use Only
Reviewed and Approved
_____

SIGNATURE:_____**DATE:**_____

When completed, please mail to: PO Box 551, Lexington, MI 48450-0551 or email to macombcms@gmail.com