Macomb

Medicus

Journal of the Macomb County Medical Society

January/
February
2020
Issue
Vol. 28
No. 1

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

Macomb Medicus

Journal of the Macomb County Medical Society

Toll Free 877-264-6592

e-mail macombcms@gmail.com

web www.macombcms.org

IN THIS ISSUE

January/February, 2020
Vol. 28, No. 1

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

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

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

Recreational Marijuana

By: Daniel M. Ryan, MD

JUST OVER A YEAR AGO MICHIGAN VOTERS LEGALIZED MARIJUANA FOR ADULT RECREATIONAL USE BY PASSING PROPOSAL 1. Proponents argued that the decreased law enforcement costs for those individuals previously arrested for marijuana offenses, and ultimately, there will be less money going to the drug cartels who are providing the substance. On the other hand, opponents argue that legalization will promote a huge marijuana industry, which will advertise and promote its use which would lead to negative health effects and an increased burden to society.

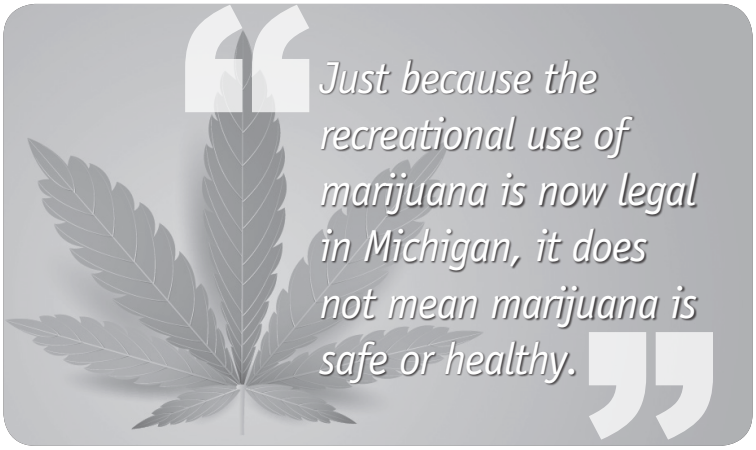
The new Michigan law stipulates that one must be at least age 21, may have up to 2.5 ounces in possession, 10 ounces at his home, and may grow up to 12 plants. Proposal 1 does stipulate that one can use marijuana in one's own home and at places that have a social consumption license. One may not use marijuana in public places including restaurants, outdoors, and cannot drive under the influence of marijuana. Employers can develop their own specific policies that prohibit its use at the workplace.

Three shops recently opened in Ann Arbor with long lines of customers proving that there is a high demand for its sale. Despite the new law and the desire for its recreational use, a majority of Michigan's communities do not want the marijuana businesses in their towns. Only 24 communities in the entire state of Michigan have approved ordinances for its recreational sale.

Here in Macomb County, the following communities have opted out of recreational sale: Armada, Chesterfield Township, Macomb Township, Memphis City, New Baltimore, Ray Township, Richmond Township and city, Romeo Village, Shelby Township, Sterling Heights, Utica, and Washington Township.

In Warren, the largest city in Macomb County and the third largest in the state, the city council only approved 15 out of 64 applications. Subsequently, the Mayor vetoed these ordinances and applications passed by the city council. Now, those businesses that applied and didn't get approval are now suing the city. Residents in other Macomb County communities that have not approved the recreational sale of marijuana are considering petitions to have the issue placed on their local ballot, hoping to override their local governing body.

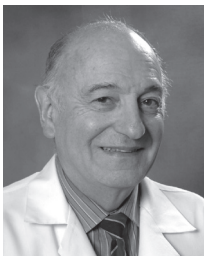
Despite these limitations in recreational use, the ongoing debate in local communities regarding how many dispensaries, how to determine who can have them, and where they can be placed is uncertain, confusing and will be an ongoing process. This, along with the lack of growers, as the Michigan Marijuana Regulatory Agency did not license growers first, has led to a shortage of supply. There has been an increase in price and a delay in availability. This, unfortunately, has helped the black market and there has been an increase in marijuana consumption which is a consistent upward trend that has occurred with every other state that has legalized it for recreational use.



As the state, local municipalities, and Macomb County continue to implement Proposal 1 the impact of the legal recreational use of marijuana in the future is uncertain. There will be an ongoing need for clarification, and there will be changes in the law as various utilization scenarios play out. Nevertheless, we as physicians can educate the community regarding the dangers of the use of marijuana, guided by the response from the Michigan State Medical Society to proposal 1: "Just because the recreational use of marijuana is now legal in Michigan, it does not mean marijuana is safe or healthy. Marijuana is still a Schedule 1 controlled substance which reflects the high potential for abuse and addiction. The recreational use of marijuana harms our communities, families, and youth. Other states have already experienced the sweeping negative consequences associated with this sort policy, which include but are not limited to increased marijuana-related hospitalizations, traffic deaths and crime. Regardless of the legality of marijuana use here in our state, Michigan's physician community will remain vigilant in working to educate and inform our patients and the broader public of the dangers associated with marijuana use."

Editor's Note: The Michigan State Medical Society continues to call for more research on the long-term health effects of expanded use of marijuana and the differences between hemp-based CBD oils and edibles and marijuana-based CBD products that contain high or uncertain levels of THC.

MICHIGAN DELEGATION TO THE AMA INTERIM MEETING REPORT



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

On November 19, the Michigan Delegation to the American Medical Association (AMA) wrapped up another successful AMA Interim Meeting. From Council representation to testimony to serving on Reference Committees, Michigan's Delegation worked hard to influence national health care policy.

In addition to bringing forth resolutions passed by the MSMS House of Delegates, the Delegation monitored and provided testimony on a variety of issues heard by six Reference Committees. Sixty-seven resolutions, seventeen Board of Trustee Reports, and nineteen AMA Council Reports were reviewed and discussed over the course of the four-day meeting.

"I commend the Michigan Delegation for their preparation to ensure the voice of Michigan physicians is well represented at the AMA House of Delegates," said Mark C. Komorowski, MD, Chair of the Michigan Delegation. "I am proud of their advocacy and dedication."

Michigan submitted eight resolutions and one memorial resolution recognizing Bassam H. Nasr, MD. As always, Michigan's resolutions touched on timely topics and generated a great deal of support. Below is a listing of the resolutions and outcomes.

10	Ban Conversion Therapy - *Adopted as Amended.*
11	End Child Marriage - *Adopted as Amended.*
211	Effects of Net Neutrality on Public Health - *Referred.*
212	Centers for Medicare and Medicaid Services Open Payments Program - *Adopted as Amended.*
811	Require Payers to Share Prior Authorization Cost Burden - *Adopted.*
922	Understanding the Effects of PFAS on Human Health Alternate Resolution 901 - *Adopted in lieu of Resolutions 901 and 922.*
923	Support Availability of Public Transit Systems - *Adopted as Amended.*
924	Update Scheduled Medication Classification - *Not Adopted.*

As noted by the number of reports presented, your BOT and Councils worked diligently to respond to the directives of the House of Delegates and their constituencies. Michigan Delegates Betty S. Chu, MD, MBA, and Pino D. Colone, MD, serve on the Council on Medical Service and Constitution and Bylaws, respectively.

Other highlights from the AMA Interim Meeting include:

- Adoption of concise policy in support of banning the sale and distribution of all e-cigarette and vaping products lacking FDA approval for tobacco-cessation purposes and made available by prescription only.
- Commitment to improving and support of racial pay equality.
- Recognition of the need to provide current and future physicians with awareness and training necessary to better treat patients facing health issues related to sexual orientation and gender identity.
- Adoption of the Council on Ethical and Judicial Affairs Report 1 titled Competence, Sell-Assessment and Self-Awareness which recognizes physicians' ethical responsibility to provide competent care is fluid and context-dependent at different phases of their careers.
- Support of free public sunscreen programs.
- Support of research, stronger public health messaging, and development of resources pertaining to the impact and use of cannabis and cannabinoids, including the creation of an AMA cannabis task force.
- Directive to develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment in order protect patients from out-of-pocket costs.
- Oppose efforts by organizations to board certify non-physician clinicians in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification or that is likely to confuse the public about the unique credentials of medical specialty board certification.
- Adoption of the Council on Medical Services Reports 3 and 4, which address the need for better risk adjustment under alternative payment models and the burden of high and escalating prescription drug prices, respectively.

WALMART DELAYS EPCS MANDATE

Walmart announced, in a statement to USA TODAY, that it will delay its self-imposed January 1, 2020 effective date for the mandated use of electronic prescribing for controlled substances (EPCS) for all controlled substances, with no exceptions. This decision follows on the heels of a letter sent by the American Medical Association (AMA) opposing the mandate, urging a delay due to the likelihood for patient harm and highlighting inconsistency with federal law.

Per Walmart spokeswoman Marilee McInnis, "We recognize not all provider networks and prescribers will have the technology and systems in place to accommodate this requirement, so we will continue to take written prescriptions so patients are not unintentionally negatively affected by this process."

AMA President Patrice A. Harris, MD, MA, provided the following statement to USA Today:

"The AMA welcomes Walmart's decision to delay implementation of an electronic prescribing mandate that would have resulted in harm to millions of Americans, including many in rural areas who rely on Walmart as the only pharmacy in reasonable distance. The policy, which the AMA urged Walmart to delay, was not developed in consultation with the nation's physicians, who support electronic prescribing of controlled substances, but want to see it implemented in a manner that supports - rather than disrupts - patient care."

"The AMA will continue to work with physicians, pharmacists, and other partners in health care to improve medication adherence, including removing barriers that impede physicians from electronically prescribing controlled substances."

While Walmart's delay provides temporary relief to many practices that do not yet have the capability to utilize EPCS and their patients, federal legislation passed and signed into law last year requires the use of EPCS for all controlled substances under Medicare Part D by January 1, 2021. Additionally, 27 state Legislatures have already adopted EPCS mandates and the Michigan Legislature is currently debating legislation that would require prescribers to electronically transmit all prescriptions, including those for controlled substances.

Below are some tips for prescribers interested in starting EPCS.

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

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

Prescribers without an EHR also have options. If currently using an electronic prescribing application for non-controlled medications, check with the vendor to see if they have a certified EPCS upgrade. If not using electronic prescribing at all, stand-alone electronic prescribing systems with EPCS are available that don't require an EHR. There are systems designed to meet a variety of needs, from those that offer simplicity and basic functionality and can be used on a smart phone or tablet (e.g., Dr. First iPrescribe) to those that will offer a fuller range of functionality (e.g., Dr. First EPCS Gold). When you make your EPCS selection, steps 1-3 outlined above for EHR users must be completed in order to send electronic prescriptions for controlled substances.

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

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

MDHHS PRESENTS NEW APPROACH TO STRENGTHEN BEHAVIORAL HEALTH AT JOINT LEGISLATIVE HEARING

On December 4, Robert Gordon, director of the Michigan Department of Health and Human Services (MDHHS), presented to a bipartisan panel of legislators the department's vision for a strengthened behavioral health system, serving individuals with severe mental illness, substance use disorders, and developmental disabilities. The new system will integrate physical and behavioral health services to improve outcomes and meet the growing demand for mental health care in Michigan.

"Michigan has a golden opportunity to improve services for our loved ones - to expand access, to reduce red tape and to strengthen our behavioral health system for the long haul," Gordon said. "We have so many strengths to build on, beginning with the heroic work of providers and caregivers statewide. We're going to build on those strengths and establish an integrated approach to care that finally treats the whole person."

Despite the strengths of the current public behavioral health system, Medicaid participants continue to face challenges, such as a lack of coordination between physical health and mental health professionals. Participants find the system confusing to navigate and it can be difficult for families to find the right services.

MDHHS proposes a new approach to behavioral health that will lead to greater choice of providers, better coordination of services, and increased investment in behavioral health. To advance these goals, Gordon outlined three key principles for system design:

- Preserving a strong safety net.
- Integrating physical and behavioral health in both care and financing.
- Establishing Specialty Integrated Plans (SIPs).

SIPs bring together the management skills of traditional insurance companies with the expertise and depth of behavioral health organizations. Already in use in other states, including North Carolina, Arizona and Arkansas, SIPs allow for stronger and simpler oversight with lower administrative costs.

The department's approach will also preserve the extra protections available today, including person-centered planning (ensuring people actively participate in the design of their care), recipient rights and comprehensive services and supports. It also creates opportunities for further innovation in how care can be delivered.

"To achieve better care for Michiganders, the department will work together with families, advocates, providers and legislators," Gordon said. "We look forward to sharing this approach with our stakeholders and especially with those we serve. Working with them, and building on the best of our current system, we will design a model that improves outcomes and treats individuals with the dignity they deserve."

It is expected the new Medicaid-funded integrated health plan will launch in 2022. Four public forums will be scheduled in January 2020 to hear feedback and questions as policy design and planning move forward.

More information can be found at Michigan.gov/FutureOfBehavioralHealth, where there is also an opportunity to provide comment on this vision to improve the public behavioral health system.

HEALTH CAN'T WAIT HEARING IS SCHEDULED FOR LATE JANUARY 2020

The Health Can't Wait coalition is planning to make our presence known when the Senate Health Policy and Human Services Committee takes up Senate Bill 612 on January 30, 2020, at 1 p.m.

Senate Bill 612, which addresses needed reforms to health plan prior authorization and step therapy programs, is set to be considered by the Senate Health Policy and Human Services Committee on January 30, 2020, at 1 p.m. (This is subject to change and we will let you know if it does). It will be a big day for the Health Can't Wait (HCW) coalition, and it is important that we make our presence felt around the Capitol before, during and after the hearing. With that said, packing the hearing room with supporters is an excellent place to start. MSMS will coordinate testimony for the HCW coalition and we have asked our coalition partners to help identify spokespeople to testify. Patient advocates who are willing to share their personal stories and provide powerful testimonials will be critical to the success of our efforts.

If you would like to attend the hearing on January 30, please contact Jennifer Finney at 517-336-5735; or at jfinney@msms.org.

More and more people are learning about the Health Can't Wait coalition and our efforts to reform prior authorization and step therapy in part because of the extensive, positive news coverage our cause continues to receive.

December 11, 2019

MCMS Annual Membership Meeting & Legislative Update

THE MACOMB COUNTY MEDICAL SOCIETY HELD ITS ANNUAL MEETING ON WEDNESDAY, DECEMBER 11 AT IKE'S RESTAURANT IN STERLING HEIGHTS.

Our guest speaker was Joshua C. Richmond, the Senior Director of Physician Engagement & Organizational Integration for the Michigan State Medical Society. He gave a very informative update on legislative issues affecting healthcare including prior authorization, step therapy, and surprise out of network billing. He also provided the guests with details on the upcoming election cycle.

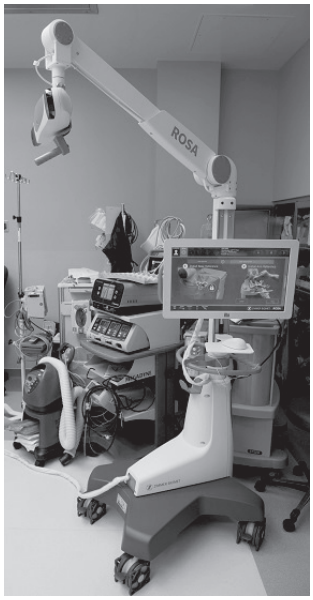
Following the Legislative Update, MCMS President-Elect Dan Ryan, MD presented a plaque of appreciation to outgoing MCMS President Vicente Redondo, MD for his service to the society this past year.

Henry Ford Macomb Hospital

ROBOTIC SURGERY FOR KNEE REPLACEMENT

Six Henry Ford Health System locations now offer knee replacement surgery using robotic technology, a new surgical option for one of the most common elective procedures performed on older adults.

Zimmer Biomet's ROSA robotic knee system is available at: Henry Ford Hospital, Henry Ford Allegiance Health, Henry Ford Macomb Hospital, Henry Ford West Bloomfield Hospital, Henry Ford Wyandotte Hospital and Henry Ford Medical Center-Cottage in Grosse Pointe Farms.



Robotic technology for joint replacement surgery was originally introduced three years ago at Henry Ford West Bloomfield, which began using Stryker's Mako robotic system for partial knee replacements and hip replacements.

"Using robotic guidance technology is a new tool to perform the surgery, and it's been shown to improve the accuracy for positioning the knee implant," says Robb Weir, MD, vice chair of Henry Ford's adult reconstruction division and chief of orthopedic surgery at Henry Ford West Bloomfield. "The technology, however, doesn't change how we perform knee replacement surgery. In this case, the surgeon uses the technology to control and move surgical instruments."

More than 600,000 knee replacements are performed each year in the United States, according to the Agency for Healthcare Research and Quality. By comparison, at least 300,000 hip replacements are performed annually.

Pain and disability often lead people to surgery.

During knee replacement surgery, the damaged cartilage and bone is removed from the knee and replaced with a prosthetic implant, whose components are made of metal, plastic or ceramic. The implant mimics the shape and movement of a natural joint.

The robotic approach uses 3D technology prior to surgery to pinpoint important markers in the knee for prepping the bone for the implant. Using a robotic surgical arm and 3D technology, the surgeon guides the implant in place while shaping and balancing the bone and ligaments to ensure a proper and precise fit.

After surgery, most Henry Ford knee replacement patients return home the same day or the next day. Generally, people between the ages of 50 and 80 undergo knee replacement. The average age for both men and women is 66.

Dr. Weir recommends patients discuss with their surgeon whether the robotic approach best meets their needs.

"The alignment you can get and the position of the parts you can get is better with robotic surgery," he says.

Whether robotic surgery results in better outcomes, pain relief, recovery and patient satisfaction is unknown currently, absent long-term clinical studies comparing robotic surgery to the traditional approach.

"The hope is that improved accuracy means greater longevity," Dr. Weir says.

Ken Scott, DO performing Michigan's first total knee arthroplasty using ROSA at Henry Ford Macomb Hospital.

REMEMBERING OUR VETERANS

On Veterans Day at Henry Ford Macomb Hospital, we sent flowers to our patients who are veterans to thank them for their service to our country, including Richard Cary, 68, who served as a Marine in Vietnam and 105-year-old Jessie Marie Ross, who worked in an airplane factory during WWII as one of the original "Rosie the Riveters."

Ascension Macomb-Oakland Hospital

INTERIM PRESIDENT FOR ASCENSION MACOMB-OAKLAND HOSPITAL

Effective Dec. 2, Gary Druskovich, MD, MBA, was appointed Interim President and CEO of Ascension Macomb-Oakland Hospital. He will report to Joe Hurshe, FACHE, Interim Chief Operating Officer, Ascension Michigan.

Dr. Druskovich is an anesthesiologist who was in private group practice for 27 years. He served nine years on the Board of Directors of Ascension Borgess, and in 2017 he became the clinical leader for both hospital and ambulatory physicians. In March 2018, he was appointed Chief Physician Officer at Ascension Borgess, where he has served as both the Chief Medical Officer of Ascension's four west Michigan hospitals and as the Clinical Vice President of West Michigan Ascension Medical Group.

Dr. Druskovich displays a keen understanding of the Ascension Mission, along with today's complex healthcare challenges. Furthermore, he possesses unwavering passion to work with physicians to achieve improvement in clinical quality and service.

In his years in western Michigan, Dr. Druskovich was an engaged member of the Kalamazoo community serving on numerous boards including Cradle Kalamazoo, Family Health Center, West Michigan Cancer Center, Kalamazoo County Medical Control Authority and the WMU Homer Stryker School of Medicine.

ASCENSION MACOMB-OAKLAND HOSPITAL OB/GYN RESIDENT RECEIVES BRINTON SCHOLARSHIP

Congratulations to Katie Quinn, DO, OB/Gyn resident, Ascension Macomb-Oakland Hospital, who received the Brinton Scholarship from the Michigan Center for Fertility & Women's Health. The scholarship is named for Dr. David Brinton, a respected Reproductive Endocrinologist in Michigan who passed away in 2017. He was thought of by his patients and colleagues as a "Gentle Giant" who gave his all to his patients for the goal of having a family. The scholarship is awarded annually to a well-deserving OB/Gyn resident who has exemplified knowledge in Reproductive Endocrinology, and shows true sincerity, compassion and respect for patients.

ASCENSION MACOMB-OAKLAND HOSPITAL FAMILY MEDICINE RESIDENT HONORED BY NATIONAL ORGANIZATIONS

Congratulations to Ryan Smith, DO, Ascension Macomb-Oakland Hospital, Chief Resident, Family Medicine, who was named the 2019 Osteopathic Resident of the Year in Family Medicine by the American Osteopathic Foundation (AOF) and the American College of Osteopathic Family Physicians (ACOFP).

Dr. Smith graduated from Michigan State University College of Osteopathic Medicine (MSUCOM) in 2017; he remains on MSUCOM's clinical faculty and serves as a resident mentor. He also serves on the ACOFP Board of Governors and is a member of the American Association of Colleges of Osteopathic Medicine's Residents and Fellows Council. Currently Chief Resident in the Ascension Macomb-Oakland Hospital family medicine program, Dr. Smith recently led a quality improvement project aimed at increasing resident competency in patient exams and outpatient procedures by incorporating clinical and physical exam skills workshops into weekly didactic sessions.

Dr. Smith is active in community outreach, volunteering with Habitat for Humanity, the 'Greening of Detroit' initiative, and the Detroit Street Care program to provide healthcare to the homeless.

"Utilizing the many roles of a family medicine physician requires an individual with relentless passion for patient-centered care," said Dr. Smith. "My goal is to provide inspiration, support, and commitment to a community in need of a holistic family medicine provider [and] continue my growth and development."

ASCENSION MACOMB-OAKLAND HOSPITAL OB/GYN RESIDENT RECEIVES RYAN SCHOLARSHIP

Congratulations to Kamila Malinowska, DO, OB/GYN Resident,

Ascension Macomb-Oakland Hospital, who received the Ryan Scholarship covering her travel and attendance at the Society of Family Planning's (SFP) annual meeting in California this past October. The SFP meeting represents the intersection of leaders and innovators in family planning who are seeking to engage the most current and groundbreaking dialogue related to high-quality, reproductive healthcare through research, discussion and robust evidence-based practice recommendations. Dr. Malinowska will also join the Ascension family as an attending physician with Macomb Gynecological Associates and plans to apply for a Ryan Foundation grant to start a comprehensive female reproductive clinic.

McLaren Macomb Hospital

MCLAREN MACOMB PARTNERS WITH CHALDEAN COMMUNITY FOUNDATION ON ANTI-SMOKING INITIATIVE

McLaren Macomb, the 288-bed health care provider serving all of Macomb County, has partnered with the Sterling Heights-based Chaldean Community Foundation on a health initiative aimed to educate their community on the harmful effects of smoking and vaping. The Chaldean Community Foundation was a recent recipient of a Tobacco Control Grant from the Michigan Department of Health and Human Services.

Per the MDHHS, Tobacco Control Grants are offered to "assist community members to quit using tobacco, prevent youth from starting to use tobacco, and create policies, systems and environmental changes that protect people from secondhand smoke."

With the rise in vaping among teens, the Chaldean Community Foundation and McLaren Macomb will focus a significant portion of their combined efforts on this group.

"We are happy to provide resources to support clients in their efforts toward quitting tobacco use and to refer clients to treating physicians," said Martin Manna, president of the Chaldean Community Foundation. "A grant from the state and a partnership with a local healthcare provider are substantial strides for our organization to support the health and wellness of our clients."

The Foundation will build awareness of the unique dangers associated with a vaping habit, accomplished through community presentations and discussions with school officials, among other informative activities.

While traditional cigarette and tobacco usage among teens has declined over recent years, the use of e-cigarettes has soared, with 26.7 percent of high school seniors reporting having vaped in the past 30 days. It is responsible for several hundred hospitalizations and dozens of deaths across the country.

When compared to non-users, e-cigarette usage is associated with a 71 percent higher risk for stroke, 59 percent for heart attack and 40 percent for coronary heart disease.

"Our organization, while always here to provide care for patients experiencing a health concern, also feels that we have a responsibility to provide for the overall health and wellbeing of our community," said Tom Brisse, president and CEO of McLaren Macomb. "We are happy and excited to combine our efforts with another esteemed local organization that shares our vision and our goals."

In an effort to help smokers kick their habits, McLaren Macomb hosts and facilitates a smoking cessation program at the Karmanos Cancer Institute at McLaren Macomb, located on the campus of McLaren Macomb in Mount Clemens.

The hospital's diagnostic imaging department also offers low-dose CT lung cancer screenings, a test to detect lung cancer in its earliest stages.

MCLAREN MACOMB EXPANDS SURGICAL TECHNOLOGY TO INCLUDE WAVELINQ 4F ENDOAVF SYSTEM

McLaren Macomb, has expanded its surgical capabilities with the addition of the WavelinQ 4F EndoAVF System, a recent innovation in endovascular arteriovenous fistula creation technology. The technology allows for the creation of an AV fistula in either the ulnar artery and ulnar vein or the radial artery and radial vein for patients with end-stage renal disease who are surviving on dialysis.

This procedure and technology provides surgeons with a minimally invasive AV fistula creation alternative to open surgery. McLaren Macomb is one of few hospitals in the region able to perform this procedure.

"Patients with end-stage renal disease have few options and even fewer minimally invasive approaches when their treatment requires the need of an AV fistula," said Joseph Cuppari, DO, a vascular surgeon at McLaren Macomb. "Being able to provide this as an option for patients who are already in a compromised position can benefit their condition by increasing our chances of successfully creating a usable fistula."

The WavelinQ 4F EndoAVF System, with its slim profile, increases the AV fistula location options and allows for additional access points in the wrist for surgeons while also reducing the risks of scarring, arm disfigurement or neurological compromise for the patient when compared to the traditional open surgical approach.

An AV fistula is the connection of an artery and vein (usually in the arm) made by a vascular surgeon to increase blood pressure in order to strengthen a weakened vein and support its growth. Without the procedure, the vein would not be able to support the needles from a dialysis unit and collapse.

End-stage renal disease is the last stage of chronic kidney disease in which the kidney is functioning at just 10 to 15 percent, requiring dialysis and/or a transplant. There are more than 400,000 people in the United States living with ESRD.

For more information on surgical capabilities and technology at McLaren Macomb, visit mclaren.org/macomb.

Vascular surgeon Dr. Joseph Cuppari (center) after completing the first WavelinQ 4F EndoAVF System procedure at McLaren Macomb.

MSMS
MICHIGAN STATE MEDICAL SOCIETY

120 W. Saginaw St. • E. Lansing, MI 48823
msms@msms.org • www.msms.org
P. 517-337-1351 • F. 517-336-5797

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

Thank You for Your Generosity

2019 MCMS Foundation Holiday Sharing Card Project Raised $4,255

We would like to thank the Macomb County Medical Society members who participated in this year's Holiday Sharing Card Project. Your generous donations enabled us to raise $2,100 for the Macomb County Food Program which feeds hungry families, children, the elderly, and disabled throughout Macomb County and $2,155 for Turning Point Shelter for women which assists victims/survivors of domestic violence, sexual assault, and homelessness.

CALL FOR OFFICER NOMINATIONS

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

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

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

MRA Emergency Rules Require New Vaping Tests, Prohibit Vitamin E Acetate

ON NOVEMBER 22, THE MARIJUANA REGULATORY AGENCY (MRA) PROMULGATED EMERGENCY RULES FOR MARIJUANA PRODUCTS INTENDED FOR INHALATION TO ADDRESS THE PUBLIC HEALTH CRISIS OF E-CIGARETTE, OR VAPING, PRODUCT USE-ASSOCIATED LUNG INJURY (EVALI) TO ENSURE THE PUBLIC HEALTH, SAFETY, AND WELFARE OF ADULT-USE AND MEDICAL MARIJUANA CONSUMERS.

"It is absolutely vital that patients and consumers know, with certainty, the ingredients in the products that they are using," said Lt. Gov. Garlin Gilchrist. "These rules require stringent testing and will continue to prioritize the health and safety of Michiganders."

"As always, our primary goal is to protect the public's health," said MRA Executive Director Andrew Brisbo. "The collaboration with our public health partners over the last several months has resulted in the issuance of these rules which will increase consumer confidence in the regulated supply of marijuana products intended for inhalation."

The MRA is now requiring that all inactive ingredients added to marijuana products be clearly listed on the product label. Additionally, marijuana licensees are prohibited from using inactive ingredients that are not approved by the Food and Drug Administration (FDA) for inhalation. All ingredients added to marijuana products intended for inhalation must be FDA-approved for inhalation and cannot exceed the maximum concentration listed in the FDA Inactive Ingredient database.

The MRA will inspect processing facilities twice a month to ensure compliance with these manufacturing standards. Also, the MRA will require licensed safety compliance facilities to test for vitamin E acetate.

> *It is absolutely vital that patients and consumers know, with certainty, the ingredients in the products that they are using.*

Effective immediately, licensees may not sell a marijuana product which is intended for inhalation (vaping) unless one of the following conditions is met:

- the product has received a passing test result under these rules
- the product was produced by a licensed processor after the effective date of these rules and in compliance with all rules promulgated by the MRA

"Prohibiting additives that could cause harm to human health is a step forward in efforts to protect the public during this outbreak of lung injury cases," said Dr. Joneigh Khaldun, chief medical executive and chief deputy for health for the Michigan Department of Health and Human Services.

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.

When Treating Kids, Learn from the Emergency Department

By: Phyllis L. Hendry, MD, FAAP, FACEP

TO PREVENT COMMUNICATION GAPS WHEN TREATING KIDS, ALL SPECIALTIES CAN BENEFIT FROM LESSONS LEARNED IN THE EMERGENCY DEPARTMENT (ED), WHERE CONVERSATIONS ARE RUSHED, STAKES ARE HIGH, TEAMS ARE ASSEMBLED AD HOC, AND PHYSICIANS SELDOM HAVE RELATIONSHIPS WITH THE PATIENT. These same conditions are becoming more prevalent in other specialties due to patient or family relocations, rapidly merging healthcare systems, and changes in employee healthcare plans or contracts. The days of having the same doctor for decades are fast disappearing.

Communication gaps are particularly risky when treating kids, because the patient often cannot communicate, and the caregiver - whether a parent, other relative, or babysitter - must speak on the patient's behalf. Poor communication not only endangers patients, but increases physicians' exposure to potential malpractice claims, according to a recent study of malpractice claims involving children. Based on 10 years of claims filed against physicians in 52 specialties and subspecialties, the study found that communication breakdowns between patients/families and providers contributed to 15 to 22 percent of claims (depending on age group).

System issues often contribute to communication failures, such as when a child's previous medical records cannot be found in an electronic health record (EHR) database because of a misspelled name or incorrect date of birth. When facing such frustrating, systemic obstacles to providing care, it is especially important for physicians to have meaningful conversations with patients and parents/caregivers. Consider that when dealing with pediatric cases, you have a minimum of two patients - the child, the parent or guardian, the actual current caregiver, sometimes grandparents offering advice, coaches, teachers, siblings, and possibly more.

Here are four communication lessons learned from the ED regarding pediatric patients based on cases seen over 30 years of pediatric EM practice:

1. Be sure caregivers understand discharge instructions.

CASE EXAMPLE: A mother brought her 10-year-old son to the ED with abdominal pain. Following examination, testing, and observation, the patient was discharged home after verbal and written instructions to return immediately if the pain or symptoms worsened or if he developed specific red-flag symptoms. Over the next 48 hours, the child did display those symptoms, but the mother called her pediatrician's office for an appointment the next day, not realizing her son needed to be seen immediately. After the boy began vomiting blood, his mother called 911. The boy arrived at the ED via ambulance in cardiac arrest and died two days later as a result of a perforated appendix.

LESSON: Both verbal and written discharge instructions are important, and they must be presented in layperson's terms. Some EHR instructions are complex and lengthy, so on a printout of instructions, highlight only key features or phone numbers. Three key components include: Follow-up details, disease or diagnosis red flags, and patient/family understanding of the treatment plan (antibiotics, physical therapy, antipyretics, and/or subspecialty referral). When conveying red-flag symptoms that indicate the patient should return, specify whom to call, the level of urgency, and the location (such as ED or clinic). Ask when the caregiver can obtain prescriptions, and if available, consider giving a first dose of medication in the clinic or ED before discharge.

Try to determine if the child has an existing relationship with a primary care physician (PCP) or subspecialist(s). Medicaid covers over 30 million children nationwide, including many high-risk children with special healthcare needs. It is important to make sure the caregiver knows the name of the child's plan, designated PCP, and contact information.

Use the teach-back method: Instead of asking patients and/or parents whether they understand, ask them to tell you what they understand they should do, and when. This ensures everyone is on the same page. For school-age children and older, engage them in the process and discussion.

2. Avoid vaccination history assumptions.

CASE EXAMPLE: A mother brought her three-month-old infant to the ED with fever of 102°F and mild cold symptoms. At triage intake, the mother stated the infant had not yet received her vaccinations. The staff and physicians initially assumed she was against vaccinations. On further questioning and review of the EHR, it was determined the mother had tried several times to obtain vaccinations for her child without success due to PCP clinic appointment availability and staffing shortages. The infant looked well but had a complete septic workup and was admitted and treated for meningitis with a good outcome. In another scenario, an eight-month-old infant presented during peak bronchiolitis season

with fever of 102.8°F. The parent gave a history of all shots being up to date. The patient was discharged with a diagnosis of upper respiratory infection and bronchiolitis but returned two days later with pneumonia and sepsis. On further inquiry, the parent was not the regular caregiver and the immunizations were not current.

LESSON: When treating children under two years of age, always request a detailed history regarding immunizations, neonatal history, and risk factors such as prematurity or chronic medical conditions. Parents often incorrectly indicate immunizations are up to date when having their child seen in the ED. Always check immunization records by asking if the parent has the patient's immunization card, reviewing the EHR, or checking your state's immunization registry (if available). Children without current immunizations and fever may require additional evaluation, and are at greater risk for serious bacterial disease. This is especially true for those under six months of age. Just because a patient is missing immunizations does not mean the parent is anti-vaccines or neglectful. There are legitimate reasons patients fall temporarily behind. Avoid making assumptions regarding the parent or caregiver that might negatively impact your communication and thought process.

3. Know your patient.

CASE EXAMPLE: Paramedics brought an African American teenager to the ED for pain. Their report to the triage nurse was that the young man probably had sickle-cell disease, had not attempted any pain relief on his own, and possibly could be a drug seeker. This same information was related to the ED physician, who initially approached the patient with frustration, but took the time to ask additional questions, including some ice-breaker questions such as: "Where do you go to school?" "What are you doing during your summer school break?" and "Tell me what you know about your disease and pain control." The physician discovered the patient was an advanced honors student at a nearby prestigious university who had finished high school early to start college. He did not have sickle cell but another hematologic condition. He was visiting grandparents and could not reach them at work. His pain medications were in his out-of-town dorm room. He wasn't sure what to do, and concerned neighbors recommended he call 911. His hematologist was consulted, and he was admitted for pain management and evaluation.

LESSON: Always confirm key elements of the history. It is difficult to get a correct history in a brief encounter, especially with someone you are meeting for the first time. Ask patients and/or parents some nonmedical getting-to-know-you questions, and confirm which adult is there with the child, the child's primary caregiver, and the child's level of functioning. What grade are they in? Do they play sports or have a hobby? Has their activity level changed? This helps give a sense of the person, and helps interpret what they say about their physical condition or what parents say about their child's condition. Always speak directly to the child and allow the child to tell part of their story, especially when dealing with adolescents.

4. Ask the right questions.

CASE EXAMPLE: A mother signed her child in at triage/registration saying that her child was running a fever at home. The child had no fever and was playful. In fact, the mother was concerned her child had been abused while staying with her ex-husband over the weekend. The child had made some concerning comments upon her return home on Monday. The mother did not wish to report this concern at check in, and said she was scared of the father.

LESSON: Do read triage notes or medical assistant/staff notes, but begin your conversation with the open-ended question: "What are you most worried about today?" This may reveal the patient's or caregiver's true presenting concern - or it may simply help them cut through all the topics they could potentially discuss and skip straight to the most pressing concern.

Finally, rapport matters. No matter how strong your emotional intelligence, you can't communicate well with everyone. A patient may be willing to confide in a female physician but not a male physician, or the other way around. A patient may understand one physician's way of explaining things better than another's. If you are not having a successful communication experience with a patient or caregiver, consider requesting that your patient see another healthcare provider if one is nearby and readily available, or include another staff member in the conversation.

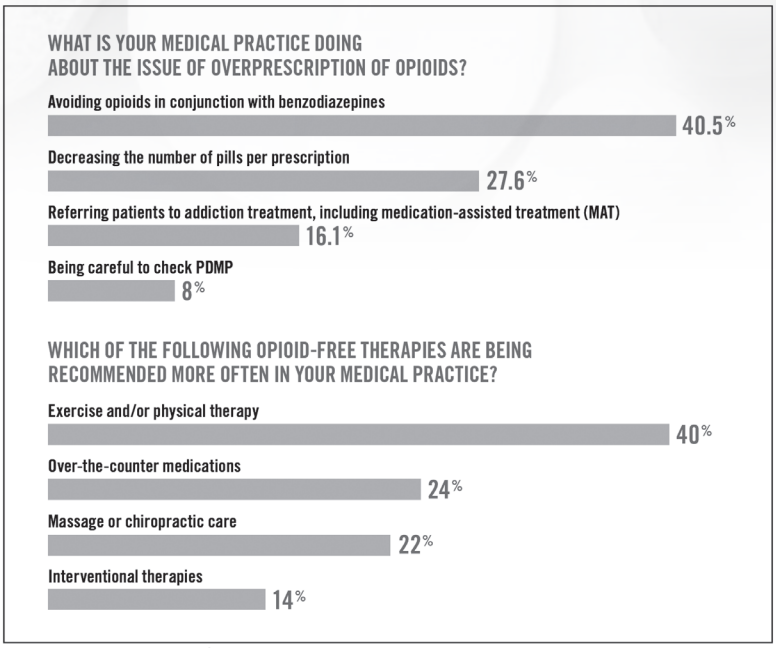
As the recent study on malpractice claims involving children shows, good communication is not a luxury. It is essential to the well-being of both patients and physicians - particularly when those patients are young and often cannot communicate for themselves.

Dr. Hendry is Professor of Emergency Medicine and Pediatrics and Associate Chair for Research, Department of Emergency Medicine, University of Florida College of Medicine - Jacksonville. She also serves as Trauma One Deputy Medical Director of Pediatric Transport and Care, UF Health, Jacksonville, and Florida EMSC Medical Director.

Response to The Doctors Company Physician Survey on Opioid Use

By Roneet Lev, MD, Chief Medical Officer, Office of National Drug Control Policy

ON BEHALF OF THE WHITE HOUSE OFFICE OF NATIONAL DRUG CONTROL POLICY (ONDCP), I WOULD LIKE TO ACKNOWLEDGE THE DOCTORS COMPANY'S HIGHLIGHTING OF THE OPIOID EPIDEMIC AND SAFE PRESCRIBING PRACTICES. The Doctors Company's social media surveys of physicians, as well as national data, demonstrate that the medical community is responding to the message about safe prescribing and is exploring solutions.



Source: The Doctors Company on Twitter (@doctorscompany)

Initial market data suggests that the total amount of opioids being prescribed monthly has dropped 34 percent from January 2017 through February 2019. The invaluable efforts of the medical community have helped to reduce the morphine milligram equivalents (MME) to 175 billion MME in 2017. That is the equivalent of 52 pills per American adult. While this is a significant improvement, it still is not near the prescribing numbers from 1992 of 25 billion MME, or 22 pills per adult.

As the Chief Medical Officer at ONDCP, I am constantly looking for new and innovative ways for the Administration to support doctors in our critical mission of saving lives. To this end, I am working to better coordinate efforts between public health, law enforcement, and community prevention programs in battling the addiction crisis across our nation.

The Administration is working to empower doctors in reducing mortality from medications by promoting safe prescribing practices. We know that the combination of multiple central nervous system depressant medications can be extremely dangerous - that includes opioids, benzodiazepines, stimulants, sleep aids, alcohol, and marijuana. Most people who fatally overdose do so on a combination of substances rather than a single medication. In 2017, the death rate for accidental overdoses on all medications, not just opioids, was 4.7 per 100,000. That is 15,173 individuals that were lost. In comparison, in 1999, the reported mortality rate was just two deaths per 100,000 or 5,628 people.

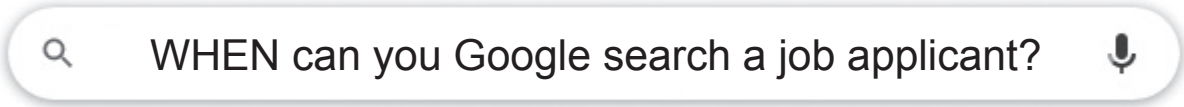
Preliminary data indicates that this trend is beginning to decrease, and I know that the medical community will respond with creative approaches and strong leadership to reduce the number of fatal overdoses due to medication, thanks to the implementation of stronger safe prescribing techniques.

Substance use disorder (SUD) affects over 20 million Americans, and the Administration is proud to report that the number of Americans accessing treatment for SUD has increased by 20 percent. Despite these gains, only 12 percent of people with SUD receive any treatment. Thank you to the many in the medical community who realize that addiction is a chronic relapsing disease (like diabetes or hypertension) that warrants treatment with compassion, and without stigma.

One way the medical community can help get more people into treatment is by increasing the ability to refer someone with an addiction to a specialist. Just as someone can be referred for orthopedics or any other specialty care, a person with an addiction needs specialized care. We are working on increasing the addiction workforce at clinics and hospitals, and encourage the medical community to reach outside their system if such services are not yet available at their institution.

Just as the medical community has helped us to reduce the number of prescriptions for high-dose opioids, it will be instrumental in promoting safe prescribing, screening for addiction, and connecting patients to addiction treatment. I, along with my colleagues at ONDCP, applaud the medical community for being a key part of our mission of saving lives.

References:
[1] IQVIA Institute for Human Data Science. Medicine use and spending in the U.S. A review of 2017 and outlook to 2022. https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022. Published April 2018. Accessed May 30, 2019.
[2] CDC WONDER data, Unintentional mortality on medications without SOOTM (synthetic opioids other than methadone). https://wonder.cdc.gov/. Accessed May 30, 2019.
[3] Substance Abuse and Mental Health Services Administration (SAMHSA). 2017 survey on drug use and health. https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH. Published 2018. Accessed May 20, 2019.



That is the question.

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

Q: I like to 'Google' job applicants before I bring them in for an interview so that I can learn more about them. Most candidates now have a Facebook page and a Twitter and/or Instagram account. Given the current state of our society, I want to make sure I'm not bringing in someone with extreme/highly offensive views, pictures of inappropriate behavior or someone who posts negative comments about past employers. Since this information is public, I thought it was okay for me to do this, but I've recently been questioned on it by another staff member and now I'm not so sure. Can I continue to 'Google' applicants before deciding if I want to interview them?

A: The real question is not 'can you?', but instead, 'WHEN can you?' Running a quick Google search on a job applicant can be considered a form of a background check. You are pulling public information related to their character and using social media sites, newspaper articles, etc. to inform your opinion about them. However, in doing so, you may also learn about their religious beliefs, their race or ethnic background, their age, their marital or familial status, etc. Making a hiring decision based on these protected classifications is considered discriminatory and is illegal. So, you need to be very careful about WHEN you run an internet search like this.

The first question you are trying to answer when considering a candidate for a job opening is, 'Are they qualified to do the job?'. Past work experience and documented skills on a resume can give you some indication of fit, but we both know that personality, communication style, expectations around hours/pay/benefits, etc. also play into whether or not someone will be the right hire for your practice. Many times, these areas are fleshed out in an interview. That interview may be over the phone or face-to-face, but the notes from that interaction provide rational for whether or not someone is still considered a qualified applicant. Once you can defend a decision of qualified vs. unqualified, it becomes less risky to run additional background/character checks where you could also learn about a person's protected classification(s). So, the short answer to your question is 'Yes'. You can 'Google' an applicant but should do so AFTER you have conducted a screening interview to determine whether or not they are qualified for the job.

Prior to running any sort of character, reference or criminal check, it is important to obtain a signed release from the applicant. This provides another layer of protection for you and informs the applicant that you will be digging into their background further, which may prompt the applicant to share information that had not previously been asked about but will most certainly come to light. The authorization to perform this search should be a standalone document if you are relying on a third party to do this on your behalf. That document needs to have language that complies with the Fair Credit Reporting Act. If you are running the search yourself, especially a Google search, then you can include authorization for this on your employment application, which the applicant completes and signs at the time of their first face-to-face interview.

Sample employment application language may read,

"I authorize PRACTICE NAME to investigate my employment history and all statements contained in this application, including records of any former employers and other references or sources concerning me. I authorize all references and sources to provide this information to PRACTICE NAME and release such references and sources from liability for doing so. I waive my right to any written notice of the release of such records that may be required by state or federal law. I understand that due to the nature of the jobs at PRACTICE NAME, an investigative consumer report may be made whereby information is obtained through interviews with various third parties. These inquires may include information as to criminal, credit, driving record, character, general reputation, personal characteristics and mode of living, whichever may be applicable. I understand I have the right to make a written request to PRACTICE NAME, within a reasonable period of time for additional information concerning the nature and scope of any investigation conducted."

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!*

SIMPLE TIPS TO HELP PHYSICIANS MASTER THE PATIENT PORTAL INBOX

Andis Robeznieks, Senior AMA News Writer

As patients become more involved in their own care, communication takes on a more important role in a patient-physician partnership. But, if not managed correctly, a practice's inbox can add another layer of administrative burden, diverting precious time to spend with patients and become a contributing factor to physician burnout.

Basic steps can be taken to make sure the messages that come to physicians through the electronic health record (EHR) in-basket or patient portal are assets and not burdens and require the expertise of a physician, as explained in the AMA STEPS Forward™ open-access module, "EHR In-Basket Restructuring for Improved Efficiency."

"One consequence of adopting an EHR is that the physician's in-basket often becomes the default destination for most forms of communication in the office," the module says. "As the physician's workload grows, so does the volume of the in-basket, creating a burden that can be difficult to effectively manage during the day."

The module was written by James Jerzak, MD, physician lead of team-based care at Bellin Health Ashwaubenon, and Christine Sinsky, MD, AMA vice president of professional satisfaction.

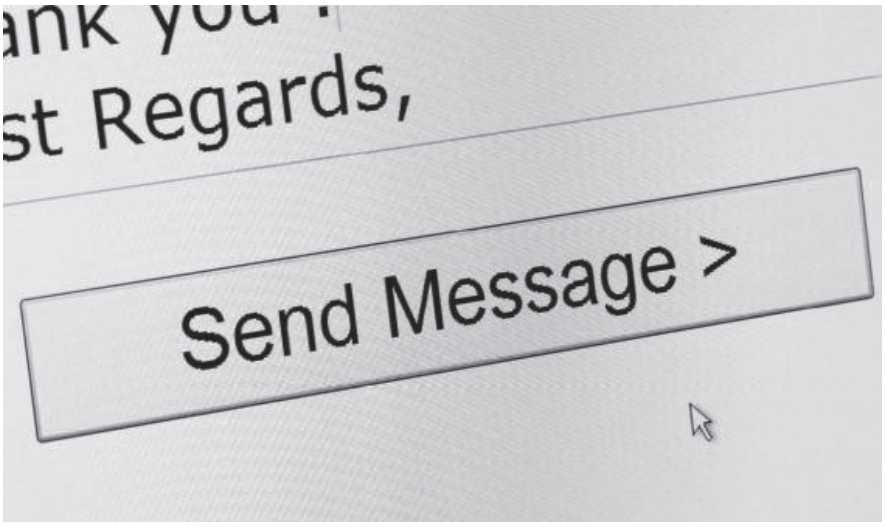
One of its key messages is that most in-basket messages do not need to be routed to the physician. The module has several other in-box management tips.

Create three overarching categories to optimize your in-basket. Work with IT experts to separate emails into these groups:

- Those that require direct physician management.
- Those that can be routed to other team members.
- Those that are not relevant to patient care or clinic business and should be filtered or deleted.

Designate which types of messages can be handled by a medical assistant, licensed nurse practitioner, registered nurse or patient services representative to help lighten physician workload.

Anticipate the needs of complex patients. A robust transitional care program that meets the needs of complex patients leaving a hospital or skilled nursing facility can reduce in-basket work and phone calls.



Co-locate team members. In-person communication is a key component of effective in-basket management. Co-location promotes team members talking to each other, resulting in less need for electronic communication that clutters the in-basket and speeding resolution of questions.

Delegate screening of portal requests. Patient portal messages should not go, by default, directly to the physician. Have these messages screened and completed by appropriate staff.

Harnessing a "fantastic tool"

In an interview with the AMA, Robert Tennant, the Medical Group Management Association's director of health information policy, said practices must have their priorities in order on portal messages.

"You don't want physicians wasting their time going through a hundred messages when only three are germane to their relationship to the patient," Tennant said, adding that portals "can be a fantastic tool" for both the administrative and clinical sides of a practice.

The "remote clipboard option" has clinical and administrative value. Sending pre-visit forms that patients fill out at their convenience instead of in a waiting room means less reliance on memory when answering questions on prescriptions, allergies, chronic illness and family history. This also means fewer errors being entered in the EHR.

Disclaimers can counteract excessive messaging. Lowering expectations by using strategic disclaimers lowers the tendency of some patients to over email and helps them understand that asking questions on a portal is not a substitute for treatment.

Tennant suggested disclaimers regarding:

- **Timing:** "While we aim to respond to inquiries as quickly as possible, we

cannot guarantee that we will do so in less than 48 hours."

- **Content:** "Use the portal only for routine questions. Please call the practice for urgent or sensitive questions."
- **Test results:** "Some laboratory results will not be displayed due to their sensitive nature. Patients are encouraged to call the practice."

Send notifications and receipts. Patients appreciate "receipt" messages such as "Your secure message was received" or notifications that they have secure messages waiting for them.

Give patients access to their records. Allow patients to download their information to their own devices or to transmit to a third party.

Include a comment box and FAQs. Give patients the ability to provide feedback and suggestions.

Learn from your peers. Ask colleagues:

- What functions work or don't work?
- What have patients told you?
- If you could start over, what would you do differently?

"Think of ways the portal can decrease administrative tasks like bill payments, appointment scheduling and prescription-refill requests," Tennant said. "Get those automated, so your staff will have time to do tasks that are more patient facing."

NEW RESEARCH LINKS HARD-TO-USE EHRS AND PHYSICIAN BURNOUT

Kevin B. O'Reilly, AMA News Editor

What's in the news: The electronic health record (EHR) systems now used in the vast majority of U.S. hospitals and physician offices get an average grade of "F" on the usability scale in the results of a newly published survey of nearly 900 doctors. Given that EHR work gobbles up as much as two hours of physicians' time for every one hour they spend delivering patient care, that result is grimly unsurprising.

After researchers adjusted for physician respondents' age, gender, medical specialty, practice setting, and hours worked, they found that how well doctors rated their EHRs' usability was "independently associated with the odds of burnout," according to a study published today in Mayo Clinic Proceedings.

> *Nearly half of American doctors exhibit at least one symptom of physician burnout.*

On a zero-to-100 scale of usability - the higher the better - every one point boost in EHR usability was linked to a 3% lower odds of physician burnout, as measured using the Maslach Burnout Inventory.

"A strong, dose-response relationship between EHR usability and the odds of burnout was observed," says the study, which was co-written by AMA professional satisfaction experts Christine Sinsky, MD, and Michael Tutty, PhD, along with leading burnout researchers from Yale, Mayo Clinic and Stanford.

"Too many physicians have experienced the demoralizing effects of cumbersome EHRs that interfere with providing first-rate medical care to patients," said AMA President Patrice A. Harris, MD, MA.

"It is a national imperative to overhaul the design and use of EHRs and reframe the technology to focus primarily on its most critical function - helping physicians care for their patients. Significantly enhancing EHR usability is key and the AMA is working to ensure a new generation of EHRs are designed to prioritize time with patients, rather than overload physicians with type-and-click tasks."

Why it matters to patients and physicians: Nearly half of American doctors exhibit at least one symptom of physician burnout, which has been linked to physicians' opting to cut back on clinical care, pursue nonclinical career options within medicine or taking their considerable talents outside the health care field altogether. That pattern is exacerbating the country's doctor shortage and access-to-care problems.

What's driving so many doctors to a state of EHR dissatisfaction? Consider this context. Previous researchers have found that Google search gets a usability score of 93 on the 100-point scale. The worst-performing everyday software product was Microsoft Excel. Yet that oft-maligned product, graded as having "low marginal" usability, still scored a 57 - nearly a dozen notches higher on the usability scale than

the 45.9 score that doctors gave the EHR on average.

Across industries, the average product score is 68 on the usability scale, yet only 15.8% of the doctors surveyed graded their EHR that highly. Researchers noted that while the relationship between usability and burnout "was strong," they "were unable to determine causation or the potential direction of effect given the cross-sectional nature of the data."

> *Today's EHRs are still in a nascent form and are only going to become more complex moving forward.*

What's next: This research measures "the overall state of EHR usability, not the usability of any specific vendor or instance of the EHR," the study's authors wrote. "The current viability variability in EHR usability across health care systems and vendors has been shown to be wide with certain tasks having an average of a nine-fold difference in time and eightfold difference in clicks" between different implementations of the same EHR and across EHRs from different vendors.

The authors noted that today's EHRs "are still in a nascent form and are only going to become more complex moving forward," the study says. Given that reality, "if EHR usability does not improve, increasing complexity could lead to compounded unintended effects on patient safety and physician burnout."

The AMA's ongoing effort to reduce physician burnout is striving to attack the dysfunction in health care by removing the obstacles and burdens that interfere with patient care.

"The AMA is working to make the patient physician relationship more valued than paperwork, preventive care the focus of the future, technology an asset and not a burden, and physician burnout a thing of the past," Dr. Harris said.

GOOGLE-ASCENSION DEAL COMES AS CONCERNS RISE ON USE OF HEALTH DATA

Kevin B. O'Reilly, AMA News Editor

What's in the news: Google and the 2,600-hospital Ascension health system are collaborating on an effort - dubbed Project Nightingale - that puts identifiable patient data in the hands of the tech giant's engineers for use in projects on machine learning (ML) and augmented intelligence (AI), often called artificial intelligence.

Google and Ascension say the activities, first reported by Rob Copeland of The Wall Street Journal, are covered by a business associate agreement, which is a long-standing, and legal, way for health care providers to share identifiable data with third parties under the Health Insurance Portability and Accountability Act (HIPAA).

The third parties may only use the data for certain purposes and must protect it as HIPAA requires. Failure to do so can result in direct liability for the business associate. The Department of Health and Human Services' Office of Civil Rights has announced that it will seek to learn more to ensure that HIPAA protections were fully implemented.

Why it matters to patients and physicians: This headline-grabbing collaboration comes as serious questions about the future of patients' data privacy take the foreground in ways that the AMA is urging doctors, patients and policymakers to take very seriously.

This much is clear: Patient privacy cannot be retrieved once it's lost. That's why the AMA has made protecting patient health data in the digital age a top priority. Above all, patients must feel confident that their personal health information will remain private. Preserving patients' trust is critical. The AMA Code of Medical Ethics offers extensive advice on privacy, confidentiality and medical records.

Anxiety around third parties, particularly technology giants, accessing and using patient health information is at an all-time high due to multiple reports on how Facebook, Google and other companies are getting their hands on this data without patients' knowledge or informed consent.

While HIPAA permits clinicians to share health care information with certain parties without a patient's consent, physicians must be responsible stewards of how patient data is disclosed. The patient-physician relationship is strengthened when patients are aware of and involved in decisions about how their information is used and disclosed.

The Google-Ascension deal raises additional questions about whether patients should be better informed about how their information is shared within the "HIPAA umbrella," whether business associates should be permitted to use patient data received through business associate agreements to build AI or ML tools that can be commercialized for later use, and whether patients should have to specifically consent to permit their data to be used to build AI or ML algorithms in the first place.

When patients learn that big tech, payers, or data brokers are commoditizing their data without their knowledge and consent - even if legally permissible - it can damage trust between patients and clinicians, particularly among populations whose data has historically been used for research without consent.

What's next: The Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare & Medicaid Services

While HIPAA permits clinicians to share health care information with certain parties without a patient's consent, physicians must be responsible stewards of how patient data is disclosed.

(CMS) are expected to soon finalize rules pertaining to health information technology that will have a significant impact on the exchange, access and use of all health care data.

As proposed, the rules would shift the paradigm from permitting data sharing to required data sharing - including with third parties who would be under no obligation to keep the information private.

The rules focus on using advanced programming interfaces (APIs) and apps to provide patients with access to their complete medical record - a fundamental right that can improve the overall effectiveness of care.

The AMA fully supports patient access to the medical record and notes that it can improve the overall effectiveness of care. It points out, however, that by virtue of patients using apps to gain information, apps' developers will gain access to the information, too.

Patients and doctors should be aware that there are other emerging technologies in which health data is not covered by HIPAA. Mobile app developers and data brokers have relatively free reign to do with it what they wish, including using it or selling it for commercial gain.

Patients may not realize that their genetic, reproductive health, substance-use disorder, mental health, and familial information can be used to limit access to health, life insurance, or be disclosed to employers. Safeguards are needed that define the digital boundary between security and exploitation, and it's the reason why collaboratively developed guidelines for privacy and other elements of these apps were released earlier this year.

Compliance with the mHealth app guidelines can provide a level of assurance that an app delivers value to patients, physicians and other users. The guidelines were developed by Xcertia, a nonprofit founded by the AMA and other major health and technology organizations.

The AMA has called on ONC and CMS to ensure that certified APIs check whether apps connecting to an electronic health record adhere to industry-recognized development guidance such as Xcertia's guidelines, transparency statements and best practices, and whether the app provides a model privacy notice to patients. This information would help provide a minimal amount of transparency to patients about how a health app will use their health information.

Regulators should take note that the Google-Ascension deal - which includes parameters around how data can be used - has caused intense public scrutiny. As proposed, CMS and ONC's rules do not have any such parameters. The AMA believes that ONC and CMS should not finalize their proposals without including an attestation framework, at a minimum. It is possible to empower access while promoting privacy and transparency - patients deserve both.

DOCTORS BACK INNOVATIVE LOCAL EFFORTS TO BATTLE OPIOID EPIDEMIC

Andis Robeznieks, Senior AMA News Writer

While recognizing that opioid-epidemic reversal strategies that may work in one community may not be transferable elsewhere, successful local programs can still provide lessons and inform the development of treatment and prevention efforts in other communities, according

> *Effective strategies and initiatives include opioid-overdose teams, needle-exchange programs, wider access to naloxone, and the establishment of drug courts that grant judges more flexibility in cases involving people arrested for an opioid-related crime.*

to an AMA Board of Trustees report whose recommendations were adopted at the 2019 AMA Interim Meeting in San Diego.

The report highlights strategies in Huntington, West Virginia, and Clark County, Indiana, and examines whether other communities could use them as examples for their own efforts.

To help address the city's opioid epidemic, Huntington used a $2 million federal grant to build a multidisciplinary "quick response team" (QRT) that included representatives from law enforcement, a paramedic, a faith-based leader and a health care provider. Data suggest that QRT efforts may help reduce opioid-related harms, according to the report. But the report raises concerns about the sustainability of QRTs in Huntington and elsewhere that use grants to fund their operation.

The effort in Clark County was directed by U.S. Surgeon General and AMA member Jerome Adams, MD, who - In his former role as Indiana state health commissioner - was in charge of the response to an HIV outbreak spread by the use of shared needles. Key to stopping the further spread of the infection was a plan that allowed injection drug users to obtain sterile needles and syringes without a prescription.

The report concludes that effective strategies and initiatives include opioid-overdose teams, needle-exchange programs, wider access to naloxone, and the establishment of drug courts that grant judges more flexibility in cases involving people arrested for an opioid-related crime.

To support the implementation of these and other effective strategies, the House of Delegates directed the AMA to:

- Encourage relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of quick response teams and other innovative local strategies to address the opioid epidemic, and share that information with the Federation of Medicine.
- Update model state legislation regarding needle and syringe exchange to state and specialty medical societies.
- Encourage drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
- Urge state and federal policymakers to enforce applicable mental health and substance-use disorder parity laws.

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, 2019

	2019	2018	2017	2016	2015
AMEBIASIS	1	0	0	1	0
BLASTOMYCOSIS	0	0	0	1	0
BOTULISM (FOODBORNE)	0	0	0	0	0
BOTULISM (INFANT)	0	0	0	0	0
BRUCELLOSIS	0	0	0	0	0
CAMPYLOBACTER	133	138	120	96	79
CHICKENPOX	60	41	31	33	32
CHLAMYDIA	2,587	3,586	3,598	3,185	2,736
COCCIDIOIDOMYCOSIS	1	4	2	2	2
CREUTZFELDT JAKOB	0	2	2	2	2
CRYPTOCOCCOSIS	1	4	1	1	1
CRYPTOSPORIDIOSIS	5	12	6	10	1
CYCLOSPORIASIS	1	1	12	2	0
DENGUE FEVER	1	0	0	1	1
DIPHTHERIA	0	0	0	0	0
EHRLICHIOSIS	0	0	0	3	0
ENCEPHALITIS PRIMARY	2	2	4	1	2
ENC POST OTHER	3	2	1	1	1
FLU-LIKE DISEASE	18,203	23,444	28,172	21,747	27,943
GIARDIASIS	21	9	20	23	17
GONORRHEA	893	1,093	946	801	522
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	9	10	9	10	4
H. FLU INVASIVE DISEASE	12	11	21	14	11
HEMOLYTIC UREMIC SYN.	2	0	0	0	0
HEPATITIS A	2	33	201	9	5
HEPATITIS B (ACUTE)	3	5	5	9	6
HEP B (CHRONIC)	90	102	108	110	125
HEPATITIS C (ACUTE)	21	31	49	31	16
HEP C (CHRONIC)	472	857	898	931	673
HEPATITIS D	0	1	0	0	0
HEPATITIS E	0	1	0	0	0
HISTOPLASMOSIS	4	3	0	5	5
HIV^	53	75	69	57	64
INFLUENZA	4,102	7,570	4,136	2,164	1,143
KAWASAKI SYNDROME	3	3	5	5	10

	2019	2018	2017	2016	2015
LEGIONELLOSIS	68	102	56	34	25
LISTERIOSIS	4	3	3	1	1
LYME DISEASE	7	8	5	3	5
MALARIA	0	2	2	2	2
MEASLES	0	0	1	0	0
MENINGITIS VIRAL	43	61	44	43	60
MENINGITIS BACTERIAL/BACTEREMIA *(EXCLUDING N. MENINGITIDIS)*	5	18	11	9	10
MENINGOCOCCAL DISEASE	0	0	0	1	1
MUMPS	2	2	3	2	0
PERTUSSIS	22	48	81	37	35
POLIO	0	0	0	0	0
PSITTACOSIS	0	0	0	0	0
Q FEVER	0	0	0	0	0
RABIES ANIMAL	1	4	2	1	1
RABIES HUMAN	0	0	0	0	0
REYE SYNDROME	0	0	0	0	0
ROCKY MNTN SPOTTED FVR	0	2	0	1	0
RUBELLA	0	0	0	0	0
SALMONELLOSIS	62	82	75	78	82
SHIGELLOSIS	20	10	46	50	22
STEC**	15	24	10	7	9
STREP DIS, INV, GRP A	36	47	32	31	27
STREP PNEUMO, INV + DR	53	54	45	55	52
SYPHILIS	83	145	84	79	108
SYPHILIS CONGENITAL	0	3	1	0	2
TETANUS	0	0	0	0	0
TOXIC SHOCK SYNDROME	1	1	0	0	1
TUBERCULOSIS	4	5	10	11	6
TULAREMIA	0	0	0	0	0
TYPHOID FEVER	2	0	0	0	1
VIBRIOSIS	0	2	0	1	0
VISA	0	2	1	0	0
WEST NILE VIRUS	2	11	7	2	4
YELLOW FEVER	0	0	0	0	0
ZIKA	0	0	0	4	0

*Includes both Probable and Confirmed case reports.

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

17-Dec-19

^ Previously reported as "AIDS"

2019-2020
Macomb County Legislator Contact Guide

Michigan Senate

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

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

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

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

Michigan House

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

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

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

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

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

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

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

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

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

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

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

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