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Toll Free 877-264-6592

e-mail macombcms@gmail.com

web www.macombcms.org

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Nobody is Immune from Burnout

By: Vincente Redondo, MD

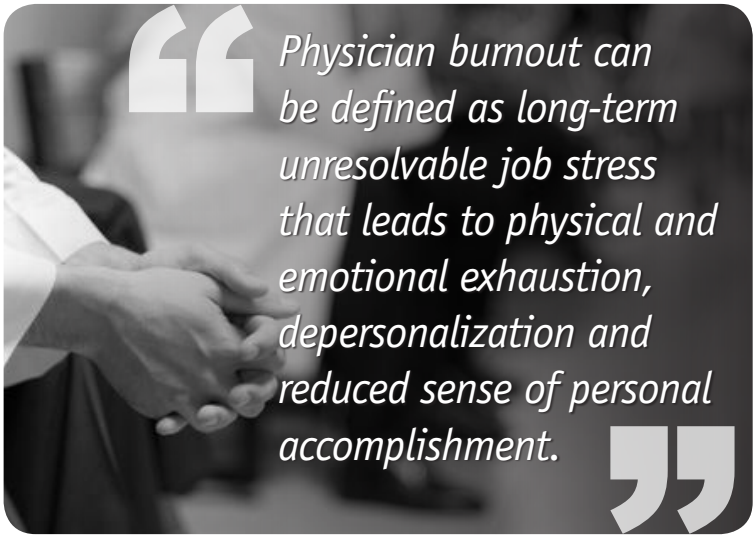
TODAY I WANT TO ADDRESS THE ISSUE OF PHYSICIAN BURNOUT. ALTHOUGH IT IS SOMETHING THAT HAS BEEN WRITTEN ABOUT QUITE EXTENSIVELY, IT APPEARS TO BE AFFECTING A PROGRESSIVELY HIGHER PERCENTAGE OF PHYSICIANS.

Physician burnout can be defined as long-term unresolvable job stress that leads to physical and emotional exhaustion, depersonalization and reduced sense of personal accomplishment. Review of recent statistics shows physician burnout between 30%-65% across all specialties, being much more prevalent in emergency medicine and primary care as well as critical care. Also, it disproportionately affects women: 50% of women versus 39% of men feel burned out. This can be explained by challenges of work life balance, as women tend to take on more family and child care responsibilities.

What are the factors that contribute to burnout? Administrative tasks and redundant work that do not improve patient care are major factors; also inability to take time off in order to try to "disconnect". Electronic medical records are a common complaint of physicians, as many of them are cumbersome and require additional time to do proper charting and documentation.

How can burnout affect one's life? One can just dread coming to work, develop cynicism, irritability that can lead to dysfunction in personal relationships at work and even at home. In some cases this can lead to clinical depression and it should be noted that suicide among physicians is higher than in the general population and specifically suicide attempts are approximately twice as frequent.

How can we deal with burnout in an effective manner? Physicians have tried different options including reducing work hours, making workflow or staff changes to help with workload, and hiring additional personnel such as a scribe to assist with electronic medical records. Physicians have tried to release stress by exercising or even trying artistic endeavors, such as painting or playing a musical instrument. Some, unfortunately, use maladaptive techniques such as drinking alcohol or substance abuse, also social isolation.

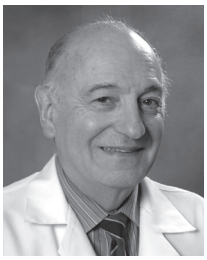


One key issue is that nobody is immune from burnout. Most especially, if it leads to clinical depression we need to be able to ask for professional help. Unfortunately, there is still significant stigma associated with mental health issues and we do not always have the necessary courage to address it properly. It is becoming even more critical that we develop support systems in our medical societies, hospitals, and medical offices so that we can effectively deal with physician burnout and its pernicious consequences.

Editor's Note:

Help is available, please visit the MCMS website for a list of Physician Wellbeing Resources. http://macombcms.org/physician-wellbeing-resources

NEW CONTROLLED SUBSTANCE PRESCRIBING RULES IN EFFECT



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

Michigan prescribers and patients have experienced the implementation of several legislative and regulatory actions intended to address Michigan's opioid crisis over the past year. Most recently, revisions to the Michigan Board of Pharmacy's Controlled Substance rules were finalized and took effect immediately upon filing with the Office of the Great Seal on January 4, 2019.

There were three important changes to the rules; perhaps most notable of which is the identification of exceptions to the "bona fide prescriber-patient relationship" requirement in MCL 333.7303a.

On April 2, 2018, the Legislature responded to stakeholder concerns by delaying the effective date of the bona fide relationship provision to March 31, 2019, or upon the promulgation of rules carving out exceptions, whichever was sooner. Because the rule establishing these exceptions was finalized with immediate effect, the requirement of a bona fide prescriber-patient relations prior to prescribing a controlled substance to patients also took effect on January 4, 2019. MSMS and many other health care stakeholders collectively advocated for exceptions that allow prescribers to provide timely, appropriate and non-duplicative care to patients. MSMS Legal Counsel has prepared a Legal Alert detailing the statutory bona fide prescriber-patient relationship requirement, the administrative rule exceptions, and suggested best practices for compliance. The related rule change is as follows:

- **R 338.3161a -** Prescribers must be in a "bona fide prescriber-patient relationship" before prescribing a controlled substance listed in schedules 2 to 5. Exceptions allowing a prescriber to prescribe a controlled substance listed in schedules 2 to 5 without first establishing a bona fide prescriber-patient relationship are recognized in the following circumstances:
  - When a prescriber is providing on-call coverage or cross-coverage for another prescriber who is not available and has established a bona fide prescriber-patient relationship with the patient, as long as the prescriber or an individual licensed under article 15 of the act, reviews the patient's relevant medical or clinical records, medical history, and any change in medical condition, and provides documentation in the patient's medical record.
  - When the prescriber is following or modifying the orders of a prescriber who has established a bona fide prescriber-patient relationship with a hospital in-patient, hospice patient, or nursing care facility resident and provides documentation in the patient's medical record.
  - When the prescriber is prescribing for a patient that has been admitted to a licensed nursing care facility or a hospice and completes the tasks required in subrule (2)(a) and (2)(b) in accordance with the nursing care facility or hospice admitting rules and provides documentation in the patient's medical record.
  - When the prescriber is prescribing for a patient, and the tasks required in subrule (2)(a) and (2)(b) are complied with by an individual licensed under article 15 of the Public Health Code and the prescriber provides documentation in the patient's medical record.
  - When the prescriber is treating a patient in a medical emergency, as defined in the rule.

In addition, prescribers need to be aware of two other important changes as follows:

- **R 338.3125 -** Gabapentin has been added to the schedule 5 drug list as a controlled substance. As a result of this change, any prescribers prescribing gabapentin must be registered with the Michigan Automated Prescription System (MAPS). Prescribers must also obtain and review the patient's MAPS report if prescribing a quantity that exceeds a 3-day supply, unless dispensed and administered to a patient within a hospital or freestanding surgical outpatient facility.
- **R 338.3135 -** Licensees applying for or holding a controlled substance license, as well as delegates who prescribe, administer, or dispense on behalf of a licensee, will be required to complete a one-time opioid and other controlled substances awareness training. This requirement does not take effect until September 1, 2019, for initial licenses and the first renewal cycle after

the promulgation of this rule for controlled substance license renewals. More details will be forthcoming from the MSMS Education Department as the compliance deadline nears.

An MSMS legal alert titled "Michigan's Bona Fide Prescriber-Patient Relationship Requirement When Prescribing Schedule 2-5 Controlled Substances" is available by visiting MSMS.org/Alerts; then click to expand "Legal" (login required).

A complete copy of the new Pharmacy - Controlled Substances Rule Set is available on the Michigan Department of Licensing and Regulatory Affairs website at www.michigan.gov/bpl.

If you have additional questions, please contact Stacey P. Hettiger, MSMS Director of Medical and Regulatory Policy at 517-336-5766.

UPGRADED ONLINE LICENSING SYSTEM MEANS NEW CSL AND DCL NUMBERS FOR SOME

Licensees with Controlled Substance License and/or Drug Control License numbers that do not start with "5315" and "5307", respectively, will be issued new numbers from the Michigan Department of Licensing and Regulatory Affairs (LARA) - Bureau of Professional Licensing. Affected licensees should have received an explanatory letter from LARA in January. If you would like to check your CSL and/or DCL license number, visit www.michigan.gov/bpl and select "Verify a License". Then search by licensee name.

LARA is transitioning to a new online licensing and regulatory database called the Michigan Professional Licensing User System (MiPLUS). In order to be compatible with the upgraded licensing platform, CSLs need to start with "5315" and DCLs with "5307". MiPLUS is expected to provide LARA staff and Michigan licensees with greater efficiencies including the following:

- Individuals can apply online, track the status of their application, renew their license, and receive electronic notifications.
- Licensees can modify their existing licensing information and upload documents.
- Licensees can self-report their convictions and disciplinary actions from other states.
- Individuals can verify the status of a licensed professional, file a complaint against a licensed professional, or report a change in staff privileges.
- Licensees can delegate another individual to pay fee or upload documents.

Nurses were the first to be phased in back in July 2017. Physicians and 10 other professionals will be part of Phase 2 which is scheduled to go live in early May. The date for Phase 3 is yet to be determined.

The issuance of new CSL and DCL numbers for the affected licensees does not require any change to the licensee's permanent professional license (MD or DO). However, any licensees who are not currently registered in the Michigan Automated Prescription System (MAPS) will have to contact the United States Drug Enforcement Agency (DEA) at www.deadiversion.usdoj.gov once they receive their new license number(s) from LARA. LARA is working with the DEA to provide them with the new license numbers for persons registered in MAPS.

Additional assistance can be obtained from LARA by emailing BPLhelp@Michigan.gov or calling 517-241-0199. You may also contact Stacey P. Hettiger at shettiger@msms.org or 517-336-5766 with questions.

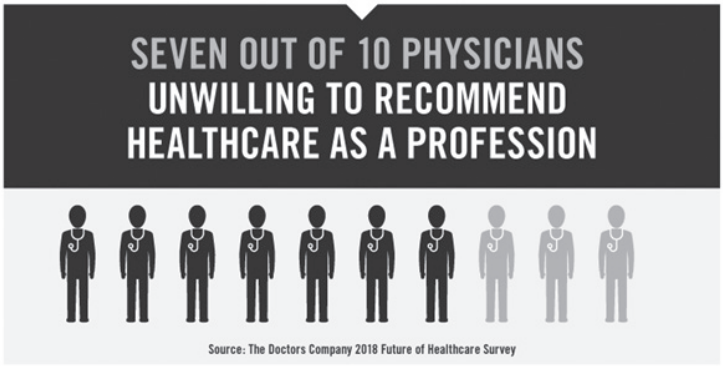
MAJORITY OF PHYSICIANS UNWILLING TO RECOMMEND MEDICAL PROFESSION

Seven out of 10 physicians are unwilling to recommend their chosen profession to their children or other family members, according to the nationwide Future of Healthcare Survey of over 3,400 physicians released by The Doctors Company. Michigan physicians' responses fell in line with the national average.

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.*



The survey further showed that over half of physicians nationwide say they are contemplating retirement within the next five years, including a third of those under the age of 50. The survey collected 2,291 written responses voicing physicians' frustration at how electronic health records (EHRs) and value-based care and reimbursement (pay for performance) are compromising the traditional doctor-patient relationship, indicating their advocacy for preserving this relationship and providing high-quality care.

Key findings of the survey included:

- 54 percent of physicians believe EHRs have had a negative impact on the physician-patient relationship.
- Half of physicians believe value-based care and reimbursement will have a negative impact on overall patient care.
- 61 percent of physicians believe EHRs are having a negative impact on their workflow, with many suggesting that EHR requirements are a major cause of burnout.
- 62 percent of physicians say they don't plan to change practice models, perhaps indicating that the pace of practice change seen in recent years may have run its course.

The survey was conducted in partnership with Modern Healthcare Custom Media.

Contributed by The Doctors Company.

STATUS OF MARIJUANA IN MICHIGAN

On November 6, 2018, Michigan joined nine other states and the District of Columbia by legalizing the recreational use of marijuana. Michigan voters approved Proposal 1 by a margin of 56 percent to 44 percent.

New State Bureau Created

The Michigan Department of Licensing and Regulatory Affairs recently announced that the newly-renamed Bureau of Marijuana Regulation (BMR) will handle all marijuana-related regulation by combining the existing oversight functions of the state's patient and caregiver registry and medical marijuana facility licensing with the newly established statutory requirements of adult-use marijuana (commonly referred to as recreational marijuana)." Additionally, the State launched a new marijuana-related website – www.michigan.gov/marijuana - which consolidates information from multiple state departments and includes links to medical marijuana facilities, registry card application information, health effects, and more.

Implementation

Although the Michigan Regulation and Taxation of Marihuana Act technically went into effect December 6, 2018, there are still many rules and regulations that will have to be issued before marijuana is widely available to the public. Although possession and use as permitted under the Act is legal, marijuana won't be commercially available for sale until LARA promulgates rules and regulations for the adult-use retail market. The statute requires LARA to be ready to accept applications for commercial licenses by mid-December 2019. Other areas of oversight by LARA include testing, packaging and labeling standards; cultivation, processing, and distribution; fees; security; record-keeping; and marketing.

Ongoing MSMS Advocacy

Regardless of one's position on the issue, the growing normalization of marijuana use either for medical or recreational purposes will present a number of legal, public health, public safety, and ethical debates over the next several years. Most notably, marijuana is still classified as a Schedule 1 drug and state laws regarding the medical and/or recreational use of marijuana is at odds with federal law and policies. This presents several challenges related to financial regulation, research, and the development of evidence-based protocols.

In 2019, MSMS and other health care stakeholders will be called upon to address consequences of and necessary safeguards related to the implementation of the Michigan Regulation and Taxation of Marihuana Act including but not limited to the following:

- Legislative advocacy to ensure patient safety
- Input on point-of-sale warnings and product labeling
- Providing input in development of rules and regulatory guidance
- Educational programming and materials for physician offices
- Ongoing communication and public awareness efforts
- Advocacy for clinical trials and improved public health surveillance efforts to obtain data on short- and long-term health effects

MSMS Resolutions

Of the five resolutions passed by the 2018 MSMS House of Delegates, three directed MSMS to take the following action should Proposal 1 pass:

Work with stakeholders to…

- Educate the Michigan public on the potential long-term deleterious effects of cannabis (58-18)
- Establish clear labeling and warnings on medical and recreational marijuana products (61-18)
- Convene a committee of physicians with expertise on potential and know risks of marijuana to develop recommendations for the Legislature (63-18)
- Communicate with physicians on this issue (63-18)

Patient Resources

Drug Facts: Marijuana – https://www.drugabuse.gov/publications/drugfacts/marijuana

CDC Marijuana Fact Sheet (Driving) - https://www.cdc.gov/marijuana/factsheets/driving.htm

CDC Marijuana Fact Sheet (Pregnancy) - https://www.cdc.gov/marijuana/factsheets/pregnancy.htm

CDC Marijuana Fact Sheet (Teens) - https://www.cdc.gov/marijuana/factsheets/teens.htm

Marijuana Talk Kit - https://drugfree.org/download/marijuana-talk-kit/

NIDA Marijuana Webpage - https://www.drugabuse.gov/drugs-abuse/marijuana

CO DPH Marijuana Fact Sheets - https://www.colorado.gov/pacific/cdphe/marijuana-fact-sheets

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Henry Ford Macomb Hospital

THE MEDALLION: MACOMB'S GALA EVENT TO BENEFIT HENRY FORD MACOMB'S SURGICAL AND TRAUMA SERVICES

The 29th annual Medallion: Macomb's Gala Event, a black-tie fundraiser for Henry Ford Macomb Hospitals, was Saturday, March 2, at Penna's of Sterling. Money raised will benefit the hospital's surgical services and trauma services.

Dr. Anthony Colucci, medical director of the hospital's Emergency Department, and his wife Lisa were the chairs of this year's event, along with co-chairs Tony and Tina Gallo. The theme of this year's event was "A Masked Ball."

The Medallion awards honor those who have worked to significantly enhance the hospital during the past year.

2019 Medallion honorees are:

TONY VIVIANO DISTINGUISHED ACHIEVEMENT AWARD:

Dr. Steve Harrington, *cardiothoracic surgeon and Cardiothoracic Services Medical Director of Quality and Development.*

PHYSICIAN:

Dr. Jerry Greib, *Emergency Department physician.*

LEADER:

Julie Carrigan, *Director of Support Services.*

NURSE:

Matthew Misch, *Cancer Care nurse.*

STAFF:

Julie Klocke, *therapeutic recreation specialist, Rehabilitation Services.*

VOLUNTEER:

Karen Watts, *volunteer in the Volunteer Services and Care Experience office.*

In addition to recognizing the Medallion honorees, the evening featured 1,000 attendees for a spectacular dinner, dancing, mock gaming and a Grand Package Raffle, including electronics, jewelry and fabulous vacation packages.

FIRST ATRIAL FIBRILLATION ABLATION PERFORMED AT HENRY FORD MACOMB HOSPITAL

Henry Ford Health System Brings Effective Arrhythmia Procedure to Macomb County

To bring world-class heart care closer to home, Henry Ford Heart & Vascular Institute cardiologists performed the first atrial fibrillation ablation procedure at Henry Ford Macomb Hospital in December 2018.

The procedure was performed by Dr. Madar Abed, an electrophysiologist. Atrial fibrillation is a malfunction of the heart's electrical system that causes an irregular heartbeat, which increases the risk of stroke or heart failure.

"With the use of advanced ablation catheters that decrease the risk of complications, we are able to perform atrial fibrillation ablation at minimal risk with excellent outcomes. In fact, ablation has become the number one choice for treatment of atrial fibrillation," said Dr. Ali Shakir, Medical Director of Electrophysiology at Henry Ford Macomb Hospital. "We are pleased to provide this cutting-edge procedure to our community through the Heart & Vascular Institute at Henry Ford Macomb Hospital."

During an ablation procedure, cardiologists access the heart through a vein in the leg. They use an electrified wire to 'burn' tiny areas of the heart experiencing electrical malfunction, rendering them obsolete. After the procedure, those areas no longer affect the patient's heartbeat, so it returns to normal.

Symptoms of an atrial fibrillation generally include heart palpitations, fatigue and shortness of breath. Medication has many potential side effects and does not cure the disease. An atrial fibrillation ablation provides significant relief of these symptoms and a better overall quality of life.

"With technological advances, we can now correct electrical short circuits that we couldn't just 10 years ago," said Dr. Sam Kazziha, Chief of Cardiovascular Services at Henry Ford Macomb Hospital. "Our brand-new electrophysiology lab is equipped with state-of-the art technology, including a 3-D mapping system to accurately map the source of the atrial fibrillation and perform successful ablations."

Atrial fibrillation ablation is one of a variety of electrophysiology services offered at Henry Ford Macomb. Others include pacemaker implant and cardiac defibrillator implant to prevent sudden cardiac death and treatment of congestive heart failure.

Henry Ford Macomb Hospital's electrophysiology team of physicians include Dr. Madar Abed, Dr. Ali Shakir and Dr. Waddah Maskoun. To request an appointment or for a second opinion, please call (800) 532-2411.

Ascension Macomb-Oakland Hospital

ASCENSION MACOMB-OAKLAND HOSPITAL APPOINTS NEW CHIEF OF CARDIOLOGY

ASCENSION MACOMB-OAKLAND HOSPITAL RESIDENTS SHINE

As Ascension residents and fellows are trained by our physicians, they are a key part of Ascension care teams making a positive impact on the lives of the patients. Many are also rising leaders in their fields of expertise. Recently, Rafael Barretto, DO, Director of Medical Education, Ascension Macomb-Oakland Hospital, shared some outstanding achievements of current Ascension Macomb-Oakland residents and faculty.

Brianna Bougoin, DO, PGY1, Family Medicine, was elected to be the Resident Council for the American College of Osteopathic Family Physicians (ACOFP).

Isabel Manzanillo-DeVore, DO, PGY 6, Fellow, earned 1st place in Endoscopy Abstract at the annual American College of Gastroenterology Convention. Her study was "A Randomized Control Trial comparing the Tolerance of Colon Prep: Same-day prep vs. split dose prep for afternoon examined."

Saroj Misra, DO, Program Director, Family Medicine, was elected to the Board of Governors for the American College of Osteopathic Family Physicians.

Raquel Pence, DO, PGY3, Family Medicine, was elected to be the Board of Directors for the Michigan Association of Osteopathic Family Physicians. Raquel was also chosen for the Future Leaders Conference for ACOFP.

Ryan Smith, DO, PGY2, Family Medicine, was chosen to be the National Resident Governor for the American College of Osteopathic Family Physicians. Ryan was chosen for the Future Leaders Conference for the ACOFP.

ASCENSION OPENS NEW ORTHOPEDIC URGENT CARE IN SHELBY TWP.

The new Ascension Stonebridge Orthopedic Urgent Care opened its doors this week to begin providing service to the greater Shelby Township community. The new orthopedic urgent care offers digital x-ray and on-site capabilities for splinting and casting, ensuring patients with sports injuries, sprains, strains or breaks will receive an evaluation and treatment in the same visit. Perfect for families and the weekend warriors.

Orthopedic specialists, Michael Wind, DO (left), and Nathan Marshall, MD (right), oversee the center which provides care seven days a week. The clinic accepts patients by walk-in or appointment and is currently working to accept online scheduling. For questions or appointment scheduling, please call (586) 254-2777.

ASCENSION MACOMB-OAKLAND DENTAL RESIDENTS PROVIDE MOUTHGUARDS TO YOUNG ATHLETES

In January, Ascension Macomb-Oakland Hospital dental residents recently volunteered their time to provide protective mouthguards to young athletes at the Downtown Detroit Boxing Gym. This program, organized by the University of Detroit Mercy School of Dentistry, includes screening, taking impressions and making the custom, protective mouthguards free of charge for each of the young athletes.

Pictured at the Boxing Gym from left: Maria Niedek, Dental Assistant; Rays (Rammiz) Khoury, DMD, Resident; Kathleen Ostrovsky, Dental Assistant; Christina van Dam, DDS, Resident; Tina Zieba, DMD, Resident; Mary Parise, DDS, Program Director; Lidya Jirjis, DDS, Resident and Samantha Kirzner, DMD, Resident.

Michigan's Bona Fide Prescriber-Patient Relationship Requirement When Prescribing Schedule 2-5 Controlled Substances

By: Daniel J. Schulte, JD, Kerr, Russell and Weber, PLC, MSMS Legal Counsel

On December 27, 2017, several bills were signed into law to address Michigan's opioid crisis. These laws contain several new requirements applicable when prescribing schedule 2-5 controlled substances. Included are new patient notification and consent requirements, a requirement to register to use and query the Michigan Automated Prescription System, limitations on prescription frequency and dosage, etc. The new requirement that a "bona fide prescriber-patient relationship" exist[1] between prescriber and patient caused great concern due to its potential to disrupt patient care and "on call"/ "coverage" relationships between prescribers. In response to these concerns, and the intense lobbying efforts of MSMS and other health care provider organizations, the Michigan Legislature, on April 2, 2018, delayed the effective date of the bona fide prescriber-patient relationship requirement until the earlier of March 31, 2019 or the date on which administrative rules providing exceptions/ clarifications to this requirement took effect. On August 31, 2018, the Michigan Department of Licensing and Regulatory Affairs filed proposed administrative rules with the Joint Committee on Administrative Rules containing exceptions to the bona fide prescriber-patient relationship requirement. These new administrative rules became effective January 4, 2019. Correspondingly, the legislatively mandated requirement of a bona fide prescriber-patient relationship prior to prescribing a controlled substance also took effect.

Provided below are details of the statutory bona fide prescriber-patient relationship requirement, the administrative rule exceptions and suggested best practices.

Statutory Bona Fide Prescriber-Patient Relationship Requirement

MCL 333.7303a(6) defines a "bona fide prescriber-patient relationship" as a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:

1. the prescriber has reviewed the patient's relevant medical or clinical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation of the patient conducted in person or via telehealth; and
2. the prescriber has created and maintained records of the patient's condition in accordance with medically accepted standards.

The bona fide prescriber-patient relationship requirement, pursuant to MCL 333.7303a(2), further requires a prescriber to provide follow-up care to the patient to monitor the efficacy of the use of the controlled substance as a treatment of the patient's medical condition.

If the prescriber is unable to provide follow-up care, the prescriber must refer the patient to the patient's primary care provider for follow-up care or, if the patient does not have a primary care provider, the prescriber must refer the patient to another licensed prescriber who is geographically accessible to the patient for follow-up care.

Administrative Rule Exceptions to The Bona Fide Prescriber-Patient Relationship Requirement

Michigan Administrative Code Rule 338.3161a contains exceptions allowing a prescriber to prescribe a controlled substance listed in schedules 2 to 5 to a patient without first establishing a bona fide prescriber-patient relationship when the prescriber is:

1. Providing on-call coverage or cross-coverage for another prescriber who is not available but has previously established a bona fide prescriber-patient relationship with the patient for whom the on-call or cross-covering prescriber is prescribing a controlled substance and the prescriber, or an individual licensed under Article 15 of the Michigan Public Health Code, reviews the patient's relevant medical or clinical records, medical history, and any change in medical condition, and provides documentation in the patient's medical record in accordance with medical accepted standards of care. (Under this exception, the existing relationship between the absent prescriber and patient allows the covering prescriber to assist the patient provided he/she reviews the patient's medical records and current health status and provides proper documentation.)
2. Following or modifying the orders of another prescriber who has established a bona fide prescriber-patient relationship with a hospital in-patient, hospice patient, or

nursing care facility resident and provides documentation in the patient's medical record in accordance with medically accepted standards of care. (Under this exception, the existing bona fide prescriber-patient relationship is sufficient for a prescriber who is acting based on existing orders related to the patient and the prescriber provides proper documentation.)

3. Prescribing for a patient who has been admitted to a licensed nursing care facility or a hospice, completes the tasks required to establish a bona fide prescriber-patient relationship in compliance with Michigan Administrative Code Rule 325.20602 or Rule 325.13302, as applicable, and provides documentation in the patient's medical record in accordance with medically accepted standards of care. (Under this exception, the bona fide relationship can be established after prescribing to a hospice patient or nursing care resident as long as it is in compliance with existing regulations and time frames.)
4. Prescribing for a patient for whom the tasks required to establish a bona fide prescriber-patient relationship have been performed by an individual licensed under Article 15 of the Michigan Public Health Code, and the prescriber provides documentation in the patient's medical record in accordance with medically accepted standards of care. (Under this exception, another licensed health professional (e.g., a physician's assistant or nurse practitioner) completes the tasks necessary to establish a bona fide relationship for the prescriber, who must then provide proper documentation in the medical record).
5. Treating a patient in a medical emergency. "Medical emergency" means a situation that, in the prescriber's good-faith professional judgment, creates an immediate threat of serious risk to the life or health of the patient for whom the controlled substance prescription is being prescribed. (Under this exception, a prescriber can treat a patient in a medical emergency without having to complete all of the tasks required to establish a bona fide relationship.)

Suggested Best Practices

1. Unless an exception applies, establish a bona fide prescriber-patient relationship prior to prescribing any controlled substance to the patient.
2. Adjust the expectations of your patients. If you anticipate they will need/seek controlled substances, tell them:
   - New legal requirements make these prescriptions burdensome.
   - You may not be able to fulfill last minute requests.
   - An in-office visit for a physical exam, notification, signature on a consent form, etc., may be necessary.
3. Develop a protocol for prescribing controlled substances and inform patients and office personnel when requests for controlled substance prescriptions over the phone or by other "telehealth" or "telemedicine" methods will be considered.
4. When covering for another physician:
   - Identify a means of communication with the absent physician in the event he or she needs to be consulted.
   - Ensure the absent physician's office staff is aware that you are covering and establish a clear manner of communication.
   - Establish a method of access to/use of the absent physician's medical records.
   - Alert office personnel that you (or another licensed provider) will need to verify whether a bona fide prescriber-patient relationship exists. Ready access to the relevant portions of the patient's medical record detailing when the absent physician last assessed the patient's medical history/current condition, whether this included an in-person/telehealth exam, etc. will be needed.
   - Establish a means of updating and providing documentation in patients' medical records. If you do not do this personally, establish a means of reviewing medical record entries made by others and the ability to make corrections.
   - Note in the medical record documentation who made the determination that a bona fide prescriber-patient relationship exists between the absent physician and the patient.
5. When modifying orders of another physician who has established a bona fide prescriber-patient relationship with a hospital in-patient, hospice patient or nursing care facility resident, include in the required medical record documentation the reason for the modification and the diagnostic information supporting it.

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[1] It should be noted that although a requirement for a bona-fide prescriber patient relationship was codified in a Michigan statute for the first time in 2017, Michigan's licensing boards and the U.S. Drug Enforcement Administration have always required that prescriptions be for legitimate medical purposes (which included the existence of a valid prescriber patient relationship).

Curbside Consultations: Patient Safety and Legal Risks

By: Susan Shepard, MSN, RN, Senior Director, Patient Safety and Risk Management Education, and Carol Murray, RHIA, CPHRM, Patient Safety Risk Manager II

INFORMAL CONSULTATIONS AMONG PRACTITIONERS REPRESENT AN IMPORTANT PART OF CLINICAL PRACTICE. They can increase knowledge among physicians and may also improve care and treatment of patients who present with complex comorbidities. Informal consultation, however, has inherent risks for the consulting physician. This article answers questions that our patient safety risk managers routinely address about the potential liability of informal "curbside" consultations.

Does the doctor run the risk of being sued because he or she provides a curbside consultation?

Risks are involved if the expectations between the physicians are not clearly communicated at the outset of the dialogue. In a classic scenario, the consulting physician is sued by a patient that he or she has neither met nor examined—and certainly doesn't remember months or years later, after a problem has developed and litigation has been initiated. Invariably, the physician offering his or her advice has made no written record of the encounter. The risk of being named in litigation increases significantly if the physician seeking advice identifies the consulting physician by name in the patient's medical record and summarizes the general nature of the conversation.

What are the legal issues raised by curbside consultations?

In a traditional face-to-face curbside consultation (as opposed to an electronic or written consultation), if an injury to the patient occurs and the patient can prove that the information provided was a proximate cause of the injury, the physician who was consulted could also be named in the lawsuit as a culpable party.

At the outset of the encounter, there must be clear communication between the physicians that identifies the nature of the inquiry and the type of guidance being solicited. In other words, if the conversation leads the attendant physician to rely on the consulting physician's response when making a treatment decision and the patient suffers harm, there could be liability for both physicians. The legal questions are "was there a physician-patient relationship between the consulted physician and the patient" and "did the consulted physician owe a duty of due care to the other physician's patient?"

For each affirmative response to the questions below, the likelihood increases that a curbside consultant will be named as a defendant:

- Did the attending physician provide detailed facts that included the patient's history, comorbidities, and laboratory data?
- Did the consultant personally review any portion of the patient's chart?
- Did the consultant speak directly with the patient or conduct even a cursory physical examination at bedside?
- Did the consultant recommend or order any specific tests, therapies, medications, or other treatment modalities?
- Did the consultant follow up with either the attending physician or the patient?
- Most importantly, did the consultant submit a bill for services rendered?

What kinds of cases have been litigated on the subject?

Our closed claims analyses revealed 21 cases in which informal consultations took place between physicians and the patient ultimately suffered serious cardiac, obstetric, neurologic, hemodynamic, or other untoward sequelae. Both physicians were named in the subsequent malpractice action. In some cases, the consultant physician shared in liability for the ultimate outcome based on his or her degree of involvement (see the factors outlined above).

Curbside consults have also moved to electronic communications. Does a doctor's professional liability insurance cover consulting with other physicians through electronic means?

It doesn't matter if the curbside consultation is electronic or face-to-face; the issues with informal consultations remain the same. However, the fact that an e-mail, text, or other electronic format allows physicians who are miles – or states – apart to communicate can also lead to other issues, such as privileging, credentialing, and physician licensure in the state where the patient resides. Professional liability insurance does not typically cover a physician for practice in a state where the physician is not licensed.

What kind of patient safety or risk management issues does this raise?

As far as patient safety is concerned, a verbal or electronic exchange between physicians may lack the patient's complete clinical picture

(which should include history, symptoms, medications, etc.). The consulted physician, by responding without having all the pertinent information, may provide advice that is not in the best interests of the patient. If the patient is harmed, the consulted physician could be held liable.

In looking at closed claims, we have learned that communication is one of the leading causes of bad outcomes. This represents a major risk with informal consultations: Communication of all the necessary information to obtain and provide good clinical advice is critical.

What criteria can be used to determine whether a situation is low risk or one that requires a formal consultation?

If the requesting physician's questions go beyond the guidelines shown below, a formal consult should be requested instead.

Low risk

- Questions are for the general education of the requesting physician and are not patient-specific.
- No request to make or confirm a diagnosis is made.
- No record review is required.
- No questions about ordering specific tests or studies are raised.
- The questions are straightforward and require only simple answers and nonspecific advice.

What can physicians do to protect themselves?

Curbside consultations are tempting to busy physicians because they are convenient and speedy. But those are the very reasons to not engage in this practice. If you decide to take on this risk, you must:

- Clarify the nature of the consult; advise the requesting physician that a curbside consultation should not be considered a formal consultation.
- Consider the facts not provided.
- Keep the consultation brief.
- Make sure the attendant physician is aware that the advice given is not a treatment decision.

If the attendant physician continues to insist that you render a treatment decision, we advise that you request a formal and documented consultation instead.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

FOUNDATION NEWS

Thank You Letter

February 4, 2019

Dear MCMS Foundation,

Our donors play a critical role in the support of our mission and the success of our survivors. Your generous collective donation of $2,915, from your Holiday Sharing Card Project, helps to fund survivors access to free, life changing programs like: 24-Hour Shelter, Personal Protective Orders, Advocacy, Sexual Assault Services, Counseling, Safety Planning and 24-Hour Help Line Support.

Since its inception in 1980 Turning Point's Shelter has housed over 22,000 women and children – with you as our partner we will continue to change lives.

Thank you for your incredible support and dedication to Turning Point! Together we can change lives!

Sincerely,

Sharman Davenport, President and CEO
Turning Point Inc.

THE DO'S AND DON'TS OF CALLING OUT A PATIENT'S BAD BEHAVIOR

Most physicians will encounter patient comments that are rude – or worse. Be prepared with a ready reply and an understanding of the ethics involved.

It's a clinical curveball, though in this case a physician in training can't turn to science for help. What does a doctor do when a patient's biased, disrespectful or hateful language threatens to get in the way of necessary treatment?

It's a situation Amy Nicole Cowan, MD, explored in a JAMA Internal Medicine essay, "Inappropriate Behavior by Patients and Their Families – Call It Out." In her commentary, she described an end-of-life situation for an elderly patient whose family members very vocally found fault with apparently everything, including the treatment team.

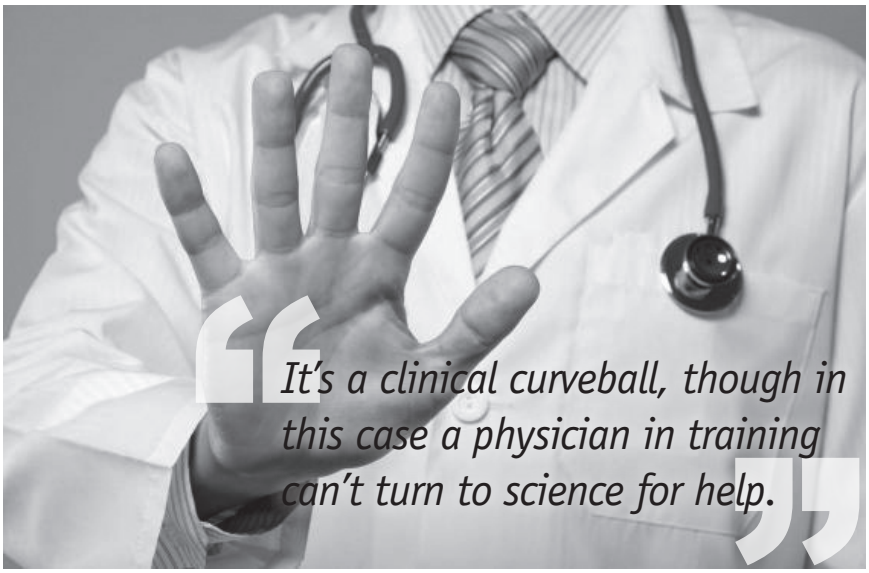
They didn't want to work with the Muslim medical student, the intern ("whom they felt was not a real physician"), the dark-skinned senior resident, or Dr. Cowan herself.

"To say that this family was disappointed when they learned that I, the attending physician, was a woman would be an understatement," she wrote.

Dr. Cowan made clear to the family that this was the team they would be working with, but the incident brought to mind similar situations that had left her feeling "stunned, feet weighted, mouth paralyzed."

She has since developed effective ways of dealing with those incidents. Here are the three key takeaways from her commentary.

Have a reply ready. "I have a quick response I can make with minimal thought," she wrote. "'We don't tolerate that kind of speech here,' or 'Let's keep it professional,' or 'I'm leaving because I don't feel comfortable' are my standard lines." It allows her to call out the objectionable behavior, "set a clear limit, and seamlessly move to the task at hand."



Be firm in the face of unacceptable behavior. "While in the moment I use plain language – no arguments, no apologizing or negotiating – when the situation later deserves to be explored, I will circle back to the bedside on my own."

Trainees and medical students need to have this taught to them. Typically, they are at a loss on how to handle such situations. Roleplaying about how to address unacceptable comments and boundary issues are now part of the hospital hallway learning she conducts alongside more traditional clinical topics.

Dr. Cowan plays the role of the aggressor and her trainees have a chance to try out a ready response. It can still be an uphill battle. "Sometimes when they cannot overcome their paralysis, I gently remind them they will not die from being uncomfortable."

Answers from medical ethics

Patient provocations are bound to happen from time to time, but professionalism is always the expectation for physicians.

Also, while clinicians are often on the receiving end of inappropriate language, some patients also report disrespectful treatment from doctors. Guidance from the AMA Code of Medical Ethics addresses the question of unacceptable from either side in Opinion 1.2.2, "Disruptive Behavior by Patients."

"Disrespectful or derogatory language or conduct on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek care, and create an environment that strains relationships among patients, physicians, and the health care team," the Code of Medical Ethics says. "Trust can be established and maintained only when there is mutual respect."

The Code says that in their interactions with patients, physicians should:

- Recognize that derogatory or disrespectful language or conduct can cause psychological harm to those they target.
- Always treat their patients with compassion and respect.

If a patient "uses derogatory language or acts in a prejudicial manner only" and refuses to "modify the conduct," the Code says, then "physician should arrange to transfer the patient's care."

Dr. Cowan's commentary captures, in practical terms, how that guidance plays out in face-to-face encounters with patients: "My message to whomever I am correcting is always the same, 'I care about

you as a person, but I will not tolerate offensive behavior. Now let's focus on how I can help you today.'"

LEVERAGING TECHNOLOGY TO BETTER MONITOR AND TREAT PATIENTS

Kelly Santomas, MS, RN, is senior director of Partners Connected Health, part of Partners HealthCare, an integrated health system founded by Brigham and Women's Hospital and Massachusetts General Hospital. In this article she looks at the necessity of using technology to better serve patients.

"Innovation" used to mean research breakthroughs, such as a new cancer treatment or a life-saving cardiac procedure. But today, it's just as likely to be synonymous with digital tools that are driving a dramatic transformation in health and wellness.

For the first time, patients can easily and securely share personal health data with their care team using their iPhone or Android devices. PGHD Connect can totally transform care delivery, including improved management of chronic illness and at-risk patient populations.

Launched in 2017, the PGHD Connect platform allows patients to share personal health data with their care team seamlessly and securely using their own consumer devices, such as blood pressure monitors, activity trackers, blood glucose monitors and weight scales. Using Bluetooth technology, the data is wirelessly transmitted into the patient's EHR.

So, instead of waiting for patients to come to the office, these Bluetooth-connected monitors can track patients' chronic conditions, allowing the provider to monitor data without patients having to make repeated trips to the office. Making monitoring more convenient can lead to wider adoption and better outcomes.

In the case of diabetes, for example, easier monitoring has the potential to reduce amputations, kidney damage and other complications, which costs $327 billion a year, according to the American Diabetes Association.

Additionally, a companion mobile app, launched this past October, makes such monitoring even more accessible. For patients who do not have Bluetooth enabled devices, the new app – which is available as a free download from Google Play and the App Store – allows patients to use their phone to take a photo of their readings and then send the data to their providers.

From the patient's perspective, both tools can mean no more little pieces of paper with readings to remember and bring in. For the physician, it can mean keeping a close eye on chronic but stable patients while using the clinical setting to see patients who are sicker.

Patients are surprisingly open to these latest innovations. They might need help setting things up, but once the technology is up and running, they are interested and receptive.

As we rolled out the new platform, my team has found provider adoption to be a bit more challenging. Physicians are already stretched thin and, at first glance, adding another thing to their workflows is reason for hesitation. Many providers might think "If all I have is 15 minutes, and I have to instruct them on how to use this technology, then what am I not going to have time to address during their visit?"

We do know that patients who are actively involved in managing their health are likely to have better outcomes and are less likely to visit the emergency department than those who are less engaged. We also know that providers worry about being factory workers making widgets instead of doctors giving care, which is why we are working hard to ensure users see this new tool as an asset, not a burden.

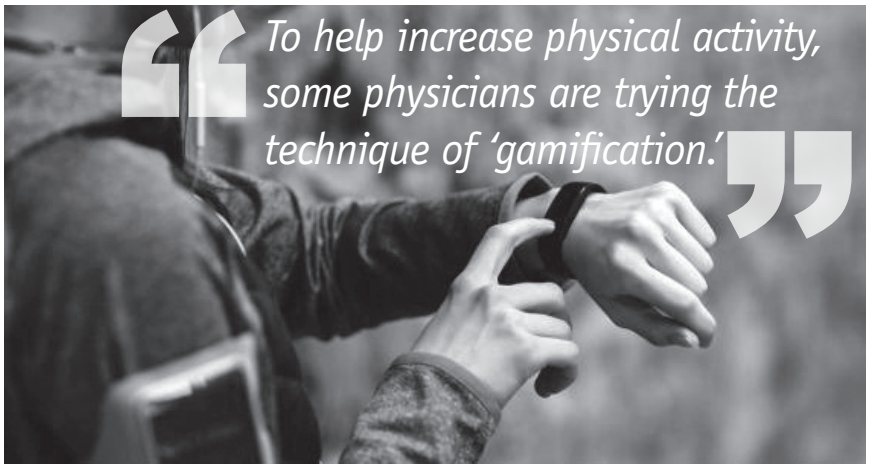
An example: One of our collaborators had a patient whose blood sugar would spike every evening, but no one could figure out why. The data provided us with a visual road map. The elevated readings caused the provider to ask what the patient was doing at the specific time. As it turned out, the patient was eating popcorn every night while watching a movie. With this information, they were able to figure it out. This shows how we can use data to keep patients from getting sicker.

While redesigning care delivery is still in its infancy, we know it's here to stay. How can we bring innovative solutions to our providers to help them manage? By 2020, there will be more Americans over age 65 than those under the age of five years old. Clearly, we are going to run out of providers if we don't leverage technology. We need to move from a one-to-one to a one-to-many care model. Our future health depends on it.

TO BOOST PHYSICAL ACTIVITY IN PATIENTS, MAKE A GAME OF IT

More than half of American adults do not obtain the recommended amount of physical activity and are at a higher risk for cardiovascular disease. To help increase physical activity, some physicians are trying the technique of "gamification," which is the application of game design elements into non-game contexts such as the use of wearable devices and counting steps.

The availability of mobile technologies such as wearable devices and smartphone apps continue to expand, providing a platform for monitoring daily health behaviors. Through game-based interventions, the researchers behind a JAMA Internal Medicine study used wearable devices and step counting to get families involved.



The study examined the effectiveness of a game-based intervention that uses collaboration, peer support and accountability to increase physical activity.

"Social incentives, or the influences that motivate individuals to adjust their behaviors based on social ties or connections, are ubiquitous and could be leveraged within gamification interventions to provide a scalable, low-cost approach to increase engagement," says the study.

The year-long Behavioral Economics Framingham Incentive Trial (BE FIT) looked at adults enrolled in the Framingham Heart Study, which is a long-standing group of families. Eligible participants downloaded an app to their phone or were sent a wrist-worn wearable device, such as a Fitbit, to track steps taken.

When designing gamification, three psychological principles were used. The principles stated that individuals are motivated by losses more than gains, behavior is better sustained by variable than constant reinforcement and individuals are motivated more by aspirational behavior at the beginning of the week as a fresh start.

"Injunctions to exercise regularly, eat a healthy diet and shed weight tend to be viewed by many patients as an obligation, a chore or a duty," Ichiro Kawachi, Phd, wrote in a commentary for JAMA Internal Medicine. He is the John L. Loeb and Frances Lehman Loeb professor of social epidemiology, and chair of the department of social and behavioral sciences at the Harvard T.H. Chan School of Public Health.

"Reframing the same behaviors as fun and challenging might be more motivating. That is, we might boost success by turning a behavior into a game," he wrote. "It is reverse engineering the process by which Pokémon Go accidentally ended up becoming the best exercise app on the market."

Friendly competition breeds success

In the BE FIT trial, families started with points they might lose if their goals were not met. Through this, the behavioral principle of loss aversion was leveraged and families were motivated to meet their daily goals. As part of gamification, each family pledged to try their best because "precommitment has been demonstrated to motivate behavior change," says the study.

To keep their points, families had to meet their step goal for the day or 10 points would be deducted from their initial 70 points. If a family member was sick or if activity was not possible, five lifelines per member were available to use. This allowed for some forgiveness and for members to ask for help.

At the end of each week, teams with a minimum of 50 points advanced up a level. Families in gold or platinum levels at the end of the intervention period received a coffee mug as a reward.

Teams took an average of 1,661 steps per day, which was significantly higher than the baseline of 636 steps. However, physical activity declined during the follow-up period. With the decline, activity remained significantly greater than in the control arm, with 1,385 steps per day compared to 738.

This level of decline in activity was also seen in a 2016 BMJ study of new Pokémon Go users. Over several weeks, the number of extra steps walked by players dropped as the novelty wore off. But some players did remain active, which was a "win for public health," according to Kawachi.

"The future of gamification – beyond providing more rigorous evaluation of effectiveness – will be in interfacing with emerging technology," Kawachi wrote. "With the advent of augmented reality gaming and "exergaming" in virtual reality, the line between entertainment and public health is becoming progressively blurred. There is an opportunity for clinicians to turn health promotion into an engaging, fulfilling and fun activity."

PHYSICIAN BURNOUT: WHICH MEDICAL SPECIALTIES FEEL THE MOST STRESS

An online survey of doctors finds an overall physician burnout rate of 44 percent, with 15 percent saying they experienced colloquial or clinical forms of depression. Two new entries in the top six specialties with the highest rates of burnout compared with last year's edition of the survey provide medical students and residents with new insight into their future careers.

More than 15,000 physicians from 29 specialties responded to the survey, conducted by the Medscape news website and called the "National Physician Burnout, Depression & Suicide Report 2019." The survey asked about the prevalence of physician burnout factors and how they affect doctors' lives. This year, while not

at the top, plastic surgery saw the biggest increase in physician burnout, climbing from 23 percent to 36 percent.

Two other specialties also saw double digit percentage-point surges. Diabetes and endocrinology rose 12 percentage points from 35 percent to 47 percent. And urology, which had the highest reported burnout, hopped from 44 percent to 54 percent, a 10-point increase.

A recent paper – published by the Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health and Harvard Global Health Institute – has documented widespread physician burnout and illustrates the growing recognition that an energized, engaged and resilient physician workforce is essential to achieving national health goals. Yet burnout is more common among physicians than other U.S. workers as mounting obstacles to patient care contribute to emotional fatigue, depersonalization and loss of enthusiasm among physicians.

The AMA is urging Congress, hospitals, and health plans to recognize the coming crisis as an early warning sign of health system dysfunction. America's physicians are the canary in the coal mine.

In the Medscape survey, last year, critical care, neurology, family medicine, obstetrics and gynecology, internal medicine and emergency medicine topped the list. However, this year the highest percentage of physician burnout occurred among these medical specialties:

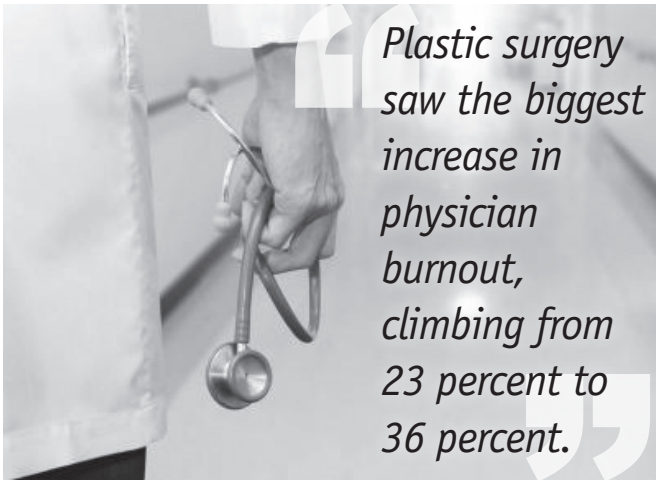
- Urology: 54 percent.
- Neurology: 53 percent.
- Physical medicine and rehabilitation: 52 percent.
- Internal medicine: 49 percent.
- Emergency medicine: 48 percent.
- Family medicine: 48 percent.

The lowest rates of burnout were reported by physicians in these medical specialties:

- Public health and preventive medicine: 28 percent
- Nephrology: 32 percent
- Pathology: 33 percent.
- Ophthalmology: 34 percent.
- Otolaryngology: 36 percent.
- Plastic surgery: 36 percent.

What factors lead to physician burnout

Almost 60 percent of respondents chose "too many bureaucratic tasks," such as charting and paperwork, as the leading cause of burnout. Spending too many hours at work (34 percent) was also a leading cause of burnout with 48 percent of physicians working 51–60 hours each week.



The medical specialties with physicians who are more likely to work long hours were:

- General surgery: 77 percent.
- Urology: 76 percent.
- Cardiology: 72 percent.
- Pulmonary medicine: 68 percent.
- Nephrology: 68 percent.

When asked how they personally cope with burnout, almost half of respondents chose exercise, while 43 percent said they talk with their family or close friends. Unfortunately, though, some physicians' coping mechanisms were less than ideal, with 42 percent stating they isolate themselves from others, while 32 percent eat junk food and 23 percent drink alcohol.

Committed to making physician burnout a thing of the past, the AMA has studied, and is addressing, issues causing and fueling physician burnout – Including time constraints, technology and regulations – to better understand and reduce the challenges physicians face. The AMA assesses an organization's well-being, and offers guidance and targeted solutions to support physician well-being and satisfaction.

The AMA Ed Hub™ (https://edhub.ama-assn.org) - your center for personalized learning from sources you trust – offers educational resources and CME on professional well-being that can help you prevent physician burnout, create the organizational foundation for joy in medicine, create a strong team culture and improve practice efficiency. Meanwhile, the AMA's STEPS Forward™ (https://edhub.ama-assn.org/steps-forward) open-access platform offers innovative strategies that allow physicians and their staff to thrive in the new health care environment.

Addressing the impact of burnout on the individual physician is an important step, yet organizational factors influence physician satisfaction as well. The STEPS Forward module, "Creating the Organizational Foundation for Joy in Medicine™," provides tools to guide the executive leadership team in creating a joyful practice environment and thriving workforce for all physicians.

New Members

LINDSAY M. BEROS, MD
Obstetrics & Gynecology – Board Certified
Medical School: Tufts University School of Medicine, 2003. Post Graduate Education: Beaumont Royal Oak Hospital, completed 2007. Hospital Affiliation: Henry Ford Macomb. Currently practicing at Henry Ford Macomb Health Center – Chesterfield, 30795 23 Mile Rd., Ste. 208, Chesterfield, MI 48047, ph. 586-421-3160, fx. 586-421-3161.

MALACHY F. BROWNE, MD
Psychiatry – Board Certified
Medical School: National University of Ireland (Dublin), 1974. Post Graduate Education: Dr. Stevens Hospital, completed in 1975; St. Joseph's Hospital, completed in 1978; Sinai Grace Hospital, completed in 1988. Currently practicing at 43171 Dalcoma Dr., Ste. 5, Clinton Township, MI 48038-6307, ph. 586-226-0682.

FARIHA HUSSAIN, MD
Pediatrics – Board Certified
Medical School: Wayne State University School of Medicine, 2015. Post Graduate Education: Children's Medical Center University of Texas, completed in 2018. Hospital Affiliation: Henry Ford Macomb, Henry Ford Detroit, Henry Ford West Bloomfield. Currently practicing at Henry Ford Macomb Hospital, Pediatrics Unit 3200, 15855 19 Mile Rd., Clinton Twp., MI 48038, ph. 586-263-2731.

March/April 2019
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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 December, 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	136	120	96	79	86
CHICKENPOX	40	31	33	32	88
CHLAMYDIA	3,670	3,598	3,185	2,736	2,474
COCCIDIOIDOMYCOSIS	4	2	2	2	7
CREUTZFELDT JAKOB	2	2	2	2	2
CRYPTOCOCCOSIS	4	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	23,444	28,172	21,747	27,943	28,824
GIARDIASIS	9	20	23	17	21
GONORRHEA	1100	946	801	522	477
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	10	9	10	4	6
HEMOLYTIC UREMIC SYN.	0	0	0	0	0
HEPATITIS A	34	201	9	5	4
HEPATITIS B (ACUTE)	4	5	9	6	7
HEP B (CHRONIC)	102	108	110	125	136
HEPATITIS C (ACUTE)	31	49	31	16	15
HEP C (CHRONIC)	848	898	931	673	693
HEPATITIS D	1	0	0	0	0
HEPATITIS E	1	0	0	0	0
H. FLU INVASIVE DISEASE	10	21	14	11	9
HISTOPLASMOSIS	3	0	5	5	2
HIV^	75	69	57	64	55
INFLUENZA	7,567	4,136	2,164	1,143	831
KAWASAKI SYNDROME	3	5	5	10	5

	2018	2017	2016	2015	2014
LEGIONELLOSIS	101	56	34	25	24
LISTERIOSIS	3	3	1	1	1
LYME DISEASE	7	5	3	5	1
MALARIA	2	2	2	2	1
MEASLES	0	1	0	0	0
MENINGITIS VIRAL	60	44	43	60	44
MENINGITIS BACTERIAL/BACTEREMIA *(EXCLUDING N. MENINGITIDIS)*	16	11	9	10	8
MENINGOCOCCAL DISEASE	0	0	1	1	1
MUMPS	1	3	2	0	2
PERTUSSIS	47	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	82	75	78	82	75
SHIGELLOSIS	10	46	50	22	9
STEC**	24	10	7	9	11
STREP DIS, INV, GRP A	46	32	31	27	26
STREP PNEUMO, INV + DR	54	45	55	52	45
SYPHILIS	132	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-Jan-19

^ Previously reported as "AIDS"

*** 2018 totals are provisional at this time.