Macomb

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Macomb Medicus

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The Vaccine Controversy: New and Old

By: Vincente Redondo, MD

THE MODERN ERA OF VACCINATION STARTED IN 1796, WHEN EDWARD JENNER INOCULATED COWPOX MATERIAL IN ORDER TO CREATE IMMUNITY TO SMALLPOX. After the individual recovered from the flu-like illness that caused this initial inoculation, he exposed the subject to smallpox material and he remained healthy, thus proving the effectiveness of this method. Obviously, this type of experiment likely would not be approved by any institutional review board today.

However, several centuries before Jenner, people all over the world used different methods to prevent infectious disease based on boosting our immune response, with variable rates of success. One such method that was notably successful, although certainly not without risk, was variolization. This method consisted of collecting scabs from patients with variola minor, a milder form of smallpox, then grinding them and either administering by scarification or by blowing the powder into the patients' nostrils. This method was used in China, India, and Africa, even before it became available in Europe and in the Americas. It was actually through African slaves that this technique was introduced in the United States. Clearly there was significant risk with this approach of immunization, as it carried a mortality of 2 to 3%, but that was definitely much lower than the 20 to 30% mortality of the natural infection.

Even though it is clear that variolation and vaccines in general have saved countless lives, there has always been an opposition from a very vocal minority of the population, going as far back as the 18th century.

In 1905, there was a case that reached the United States Supreme Court, where an individual stated that mandatory smallpox vaccination violated his right to care for his own body how he knew best. The court rejected his challenge and it was a seminal ruling, that lay the foundation for state actions to limit individual liberties in order to protect public health.

There are several arguments used by people who oppose vaccinations, one being religious. Although uncommon, certain religious groups believe in prayer as a method of healing and believe that medical interventions including vaccines are not necessary. Other religious denominations recommend staying away from vaccines that have been made using line cells derived from aborted fetuses. As an example of the consequences of religious beliefs, there was a large measles epidemic in Philadelphia in 1990 among school children who were members of a certain faith that opposed vaccines. Another outbreak occurred in a similar community in 1994.

Often the reason for the publics' opposition to vaccination is not religious, but is suspicion and mistrust.

In some cases the lack of trust in the pharmaceutical industry, has created all sorts of conspiracy theories that spread through the Internet like wild fire, particularly in these times of fake news. In certain regions of Asia and Africa there are concerns that Western countries are trying to harm and sterilize non Western communities. The harm caused by these ideas has been incalculable; a case in point, Polio is still endemic in Afghanistan, Pakistan, and Nigeria. In order to fight these deadly misconceptions about vaccines vast resources are needed to educate the public.

The most recent vaccine controversy in the United States dates back to a documentary from 1982 that described alleged adverse effects of the DTP vaccine, specifically neurological disorders. Later on in 1998, there was an article in the Lancet that stated that the MMR vaccine caused autism. This brought about great concern and many parents were discouraged from vaccinating their children. There have been countless studies disproving these findings. Even the Lancet itself published a retraction when it was discovered that data used by the author, Dr. Wakefield, was flawed and had been falsified.

Now fast forward to 2019 where we are currently dealing with a measles epidemic in our communities. This is a disease that is completely preventable by an extremely safe and effective vaccine.

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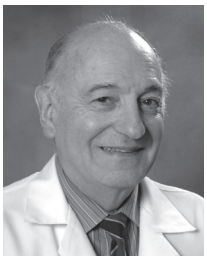
MSMS BOARD MEETS: MDPAC AND POSITIVE MEMBERSHIP WERE HIGHLIGHTED



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

On March 27, 2019, the Michigan State Medical Society (MSMS) Board of Directors heard a presentation from Blue Cross Blue Shield of Michigan, discussed current legislation, MDPAC and the importance of MSMS's political action committee, and reviewed its audited financial statements.

Health Care Delivery -

BCBSM Presentation: As a part of MSMS' payer advocacy efforts, the Health Care Delivery Board Committee regularly meets with health plans. At this meeting, Marc Keshishian, MD, Senior Vice President and Chief Medical Officer, Blue Care Network, and Vice President, Health and Clinical Affairs, BCBSM, provided an overview of BCN's business strategy and priorities for the year. The Committee had a productive discussion on BCN's administrative programs and medical policy.

CY 2019 Medicare Physician Fee Schedule and Quality Payment Program Final Rule: On November 1, 2018, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2019.

MSMS, the American Medical Association, and numerous other stakeholders submitted comments while the rule was under review. Several of the items for which MSMS and others advocated were considered favorably by CMS. Of most concern was CMS' proposal to collapse the payment rates for eight office visit services for new and established patients down to two each. CMS modified and delayed this proposal.

MSMS Coding Program: MSMS developed a three-hour educational program, "Medical Necessity - Tips on Documentation to Prove It," which was offered at the 2018 Annual Scientific Meeting and on Wednesday, March 6, at MSMS Headquarters. It will also be available in conjunction with the Spring Scientific Meeting on Thursday, May 16, at the DoubleTree, in Dearborn.

On-Demand Webinars: MSMS continues to provide on-demand webinars so MSMS members can earn CME on their own schedule, when it is convenient for them. There are currently 36 webinars available for members, with 25 of them at no cost.

Legislation -

House Bill 4026 -- Concealed Pistols in Gun-Free Zones

Introduced by Reps. Beau LaFave, Steven Johnson, and Gregory Markkanen on January 10, 2019

An act to regulate and license the selling, purchasing, possessing, and carrying of certain firearms, gas ejecting devices, and electro-muscular disruption devices; to prohibit the buying, selling, or carrying of certain firearms, gas ejecting devices, and electro-muscular disruption devices without a license or other authorization; to provide for the forfeiture of firearms and electro-muscular disruption devices under certain circumstances; to provide for penalties and remedies; to provide immunity from civil liability under certain circumstances; to prescribe the powers and duties of certain state and local agencies; to prohibit certain conduct against individuals who apply for or receive a license to carry a concealed pistol; to make appropriations; to prescribe certain conditions for the appropriations; and to repeal all acts and parts of acts inconsistent with this act.

The MSMS Board of Directors voted unanimously to oppose House Bill 4026.

MDPAC: The MSMS Board of Directors discussed the importance of the Michigan Doctors' Political Action Committee (MDPAC) and how important it is for the physician community to contribute. MDPAC can make its voice heard by supporting candidates that put the needs of physicians and patients above those of profiteering trial lawyers. We need your help. Please consider contributed to amplify the physician and patient voices by supporting MDPAC today.

Finance -

Audit: The auditors reviewed the financial statements, which were given a clean, "unmodified opinion" by the auditing firm, the highest standard of audit.

Membership: The MSMS Board of Directors were also made aware of the positive trend in the society's membership, which is projected to show an increase for 2019.

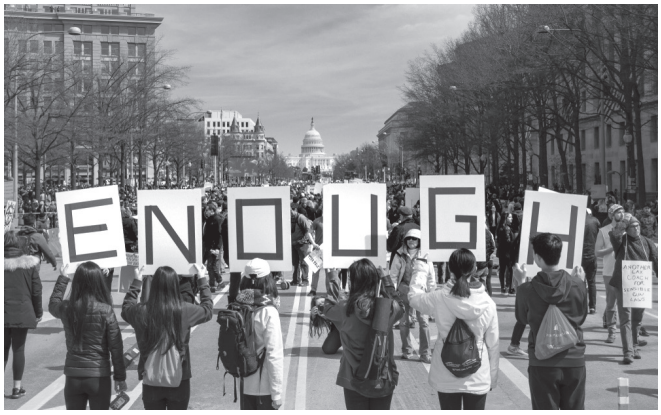
MSMS ADVOCATES TO CURB GUN VIOLENCE

Every day, 100 Americans are killed with guns and hundreds more are shot and injured. Michigan ranks among the top 10 states for gun violence, with a firearm death rate of 12.3 percent. The Michigan State Medical Society (MSMS) has taken an active role in speaking out against gun violence and making it known, we want to help solve these problems in both our state and nation.

During the past several years, MSMS has adopted several policy positions aimed at curbing gun violence. Our physician members work hard every day in their practices and communities to identify mental health issues and other concerns that could lead to tragedy.

MSMS in partnership with the Henry Ford Medical Group recently sent a letter to Senators Debbie Stabenow and Gary Peters in support of federal bill H.R. 8, the Bipartisan Background Checks Act of 2019, calling on them to consider us an ally on this issue going forward. Introduced by Representative Mike Thompson (D-CA) and Peter King (R-NY), this important piece of legislation would close an existing loophole that has allowed sales of firearms at gun shows, over the internet and person-to-person to occur without an accompanying background check. This measure passed the U.S. House of Representatives and is under consideration in the U.S. Senate.

In March of 2018, MSMS President, Betty S. Chu, MD, MBA wrote an op-ed column that was featured in the Detroit News. In it she states, "I write on behalf of Michigan physicians everywhere when I ask when and how we can -- as a society -- begin working together to solve our problems related to gun violence in our state and



nation." She also cites a report from the Centers for Disease Control reporting more than 33,000 people losing their lives each year. In her closing remarks she asks, "it is way past time to move forward in fixing the elements that lead to gun violence. The dialogue won't be easy, but it's absolutely necessary."

MSMS will continue to have the tough conversations surrounding gun violence. We will advocate to curb gun violence and support laws that do so.

If you have questions regarding MSMS policy on gun violence or want to get involved in our advocacy efforts, please contact, Christin Nohner, MSMS Director of Federal and State Government Relations.

MSMS PROVIDES COMMENTS ON MDHHS'S REPORTING OF POISONING RULES

The Michigan State Medical Society (MSMS) provided comments on rules presented by the Michigan Department of Health and Human Services (MDHHS) on the reporting of poisoning due to the use of prescription or illicit drugs.

These rules would replace emergency rules addressing the increase in poisonings due to prescription and illicit drug overdoses that are set to expire shortly. Pursuant to the proposed rules, MDHHS will use reported data to identify drugs associated with overdose injury and death, and to guide and evaluate public health response

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This illustrates how difficult it is to fight some entrenched ideas despite extensive campaigns by Public Health authorities and everyday efforts of primary care physicians, particularly pediatricians and family physicians.

I do not know what the right solution is. But surely mandatory vaccination with very narrow exceptions, in an attempt to achieve some degree of herd immunity, should be a strong consideration before the next public health emergency arrives. Regardless of whether or not this is a popular option it needs to be cogitated. As a matter of fact, New York has declared a Public Health Emergency making the MMR vaccination mandatory, including the Ultra-Orthodox Jewish community, in order to control their current measles epidemic.

to the opioid epidemic. This will include planning and targeting of resources and interventions to populations and geographies of high need.

This rules set was modeled after rules related to injury reporting and non-medicinal chemical poisoning reporting. The rule makes it possible for MDHHS to require reporting of this information from health care providers and facilities when needed. The reporting request to providers could come in two ways:

1. **Routine Surveillance Data Request:** MDHHS is developing a system to collect information on medicinal and illicit drug poisoning events using existing information feeds. This system will utilize admission/discharge/transfer (ADT) messages from health facilities to identify events with an ICD-10 code related to poisonings and overdoses. This system will be automated, and, as far as we understand at this time, health care professionals and health facilities will not have to enter data, use a list of ICD-10 codes to select cases, or retain data files for future use. MDHHS and the Michigan Health Information Network (MiHIN) are working together to develop the use case for this system now and will be including feedback from MHA and representation from health facilities and health professional organizations (including Medical Examiners) and local public health partners in the requirements development. MDHHS will not be making a request for ongoing submission of routine medicinal and illicit drug poisoning event surveillance data until the forthcoming ADT message system is established, tested, and ready to receive referrals.
2. **Specific Event Investigation Request:** In the case of a suspected outbreak of overdoses or poisoning events, this rule would be used by MDHHS or local public health to obtain information on the circumstances around those specific cases. This information would be used to aid in immediate public health response. MDHHS or local public health would contact the health care provider caring for those overdose cases, as is done currently for communicable disease investigation.

The vast majority of acute medicinal and illicit drug poisoning health care encounters are already represented in existing ADT message data flows. To the extent that these medicinal and illicit drug poisoning events are captured by the ADT messages that health care providers are already submitting, additional messages will not be needed as the new system should automatically capture these existing messages. However, this new system will also include a manual ëevent referral' screen. If any medicinal and illicit drug poisoning event is inadvertently missed/not captured, or if a health care provider is not actively sending ADT messages, health care providers will be able to log into this system to manually refer these events.

The current emergency and proposed replacement rules require that health professionals and health facilities provide reports when requested. "Health facility" means any facility or agency licensed under article 17 of the public health code, MCL 333.20101 to 333.22260 that provides health care services. The rule mentions a hospital, clinical laboratory, surgical outpatient facility, health maintenance organization, nursing home, home for the aged, county medical care facility, and ambulance operation. Health facility does not include any facility or agency that is prohibited by law under 42 CFR Part 2 from releasing records on substance abuse disorders. Hospice is specifically not listed as a health facility in this rule. Rural health clinics are not covered under the current emergency rule. This gap will be addressed in the permanent rule. "Health professional" means a person licensed under article 15 of the public health code, MCL 333.16101 to 333.18838, in medicine, osteopathic medicine, as a physician's assistant, or nurse practitioner.

The emergency rules were entered under the authority of MCL 24.248. The emergency rules are effective for 180 days. The rule promulgation process on the permanent rules is expected to be completed on or before April 26, 2019.

Questions regarding the rule making process, MSMS's comments on the rule, or additional information can be directed to Christin Nohner, MSMS Director, State and Federal Government Relations.

EXPANDING ACCESS TO MEDICATION - ASSISTED THERAPY THE NEXT BATTLE IN WAR ON OPIOID ABUSE

In October 2017, President Donald Trump declared opioid addiction a health emergency, calling it the worst drug crisis in U.S. history. Drug overdoses killed more than 72,000 Americans in 2017, and over 49,000 deaths were attributed to opioids.

Michigan remains stubbornly at the heart of the crisis. Moving beyond it - and saving lives - is going to require new and dynamic approaches to battle addiction, and embracing proven new solutions

that help individuals beat it. Michigan's physicians are on the frontlines of the fight, they've championed critical reforms, and they've implemented them. To really make a difference in this fight, MSMS continues to work on the state and national levels - with providers and with policymakers - to empower physicians with better access to proven medication-assisted therapies (MATs).

Medication-assisted treatment is an evidence-based treatment for opioid addiction that involves the use of any of a few specific medicines that stop the physical symptoms of withdrawal and controls cravings for opioids. The medicine allows the patient to do the hard work of recovery, including 12-step meetings, individual therapy, and group therapy.

"The goal of these psychosocial interventions is to teach the individual to live life on life's terms without using mind-altering substances," said Sandy Dettmann, MD, DABAM, FASAM, the Founder and Addiction Medicine Specialist at The Dettmann Center P.C. "As the patient gains coping skills and rebuilds his or her life, the dose of medication can be tapered. MAT should always be combined with solid psychosocial interventions."

According to research published by Pew Trusts, MAT reduces illicit drug use, disease rates, overdoses and crime. Patients who use medications to treat opioid abuse are less likely to use illegal opioids, and walk longer on the road to recovery.

Additional research published in the Journal of Substance Abuse Treatment indicates the use of MATs saves money. Their work says MATs reduce general health care expenditures, lower the frequency of their use, decrease inpatient hospital admissions, and lower outpatient emergency department visits.

"Unfortunately, access to MAT is a struggle, given the limited number or clinicians who practice addiction medicine," said Edward A. Jouney, DO, the Associate Medical Director for University of Michigan Addiction Treatment Services. "There are too few clinicians certified to prescribe buprenorphine, and this limits access to care. Methadone is an excellent treatment with nearly a 50 year track record. However, many counties in Michigan and even some states do not have methadone maintenance clinics. Naltrexone can be prescribed by any licensed prescriber, but the number of clinicians familiar with the fundamentals of addiction treatment are scarce."

The statistics are startling. 90 percent of patients who need addiction treatment services don't have access to treatment, and patients need full access to treatment, with as few barriers related to coverage, formularies, and administrative burdens as possible.

Better embracing the promise of MAT requires a multipronged approach - reform at the payer level to tear down barriers for patients to take advantage of effective treatments, and a more robust embrace by health care providers across Michigan.

Legally prescribing buprenorphine products requires a DATA 2000 waiver, issued by the DEA. Courses are offered at the MSMS Foundation's scientific meeting but also by both the American Society of Addiction Medicine and by the Michigan Opioid Collaborative (MOC), and physicians have a variety of ways to complete their training, including live sessions, web-based training, or a combination of the two.

Doctor Dettman suggests physicians get trained, and in the meantime, know which other physicians can help. "All prescribers should have a list of addiction medicine specialists to whom they can easily refer patients when the need arises."

Members are encouraged to contact the Michigan State Medical Society to help identify training opportunities, and reliable clinics and addiction medicine specialists in their area.

Together, we're saving lives.

PATIENTS, DOCTORS, PROVIDERS SAY HEALTH CAN'T WAIT

Prior authorization red tape and step therapy delays care and treatment for Michigan patients

Michigan physicians, clinicians, and health care providers see it every day. They examine patients, and together form a plan of care, often including additional tests, prescription medicines, and treatments - before insurance companies step in with prior authorization and step therapy red tape to prevent patients from immediately accessing the care they need.

When insurance company bureaucracy gets between a physician and his or her patient, patients get sicker, health conditions worsen, and the cost of care skyrockets. That's not right. Health can't wait, and we're doing something about it.

We are excited this week to launch a groundbreaking new effort to improve patient care.

Health Can't Wait is a coalition of patients, health care providers, and patient-support groups working together to put Michigan patients first by ending dangerous delays in patients' access to health care caused by insurance company bureaucracy, including

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prior authorization red tape and step therapy requirements.

The coalition is being led by more than a dozen patient advocacy and health care organizations, including the American Cancer Society Cancer Action Network, Susan G. Komen Michigan, the Michigan State Medical Society and many, many more.

You can learn more about Health Can't Wait, the growing coalition, and its work online at HealthCantWait.org.

But we need your help! There are three things you can do to make a difference.

First, share your story. Have you, a patient, or a member of your health care team witnessed or experienced a delay in care caused by prior authorization or step therapy? You can share your story - and your patients can share theirs - online at HealthCantWait.org. Your patients' willingness to speak out about the impact insurance company red tape has had on their health couldn't be more important, and sharing their story couldn't be easier.

Second, share the news about the coalition and the importance of this reform. Share the website on social media. Speak out to your friends, family and colleagues, and consider reaching out to your own lawmaker to encourage reform. The team at MSMS is standing by to help you craft and share your story and to connect you directly with your state legislators.

Third, please consider a donation to Health Can't Wait. Simply click "contribute" on the website to join our team. Your contribution could make all the difference.

The Health Can't Wait coalition's work couldn't be more important. 94 percent of Michigan physicians report that prior authorization red tape causes delays in care for their patients. Prior authorization red tape is part of a staggering 92 percent of all care delays, and those delays can be devastating.

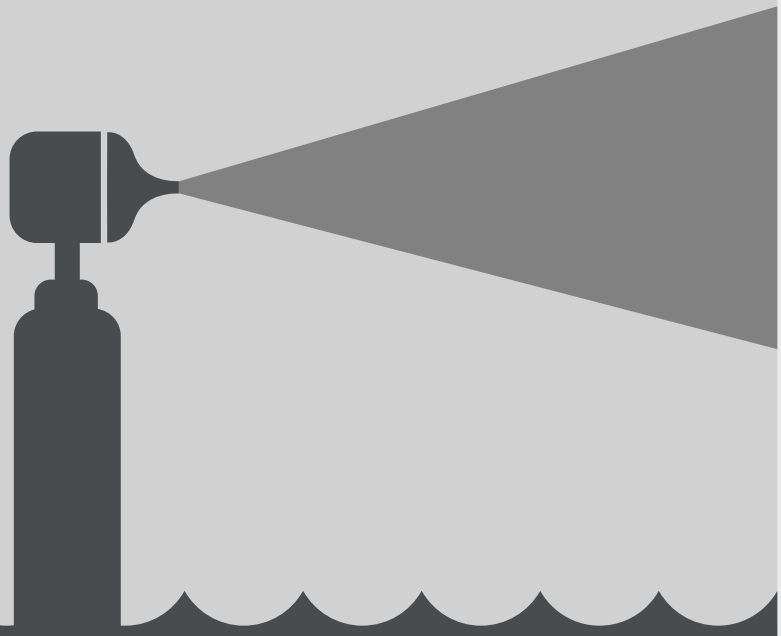
In fact, 78 percent of physicians trace prescription and treatment non-adherence to prior authorization delays. In other words, when red tape and bureaucracy prevents patients from timely access to the medicine and treatment they need, those patients are dramatically more likely to suffer the devastating health effects that come from nonadherence.

Sicker patients. More frequent visits to the emergency room. Longer hospital stays. Bigger bills. That's not right. Health can't wait.

Looking to avoid risk?

WE CAN SHOW YOU THE WAY.

We're taking the mal out of malpractice insurance. Thanks to our national scope, regional experts, and data-driven insights, we're uniquely positioned to spot trends early. We shine a light on risks that others can't see, letting you focus on caring for patients instead of defending your practice. It's a stronger vision that creates malpractice insurance without the mal.
Join us at **thedoctors.com**



THE DOCTORS COMPANY
medical ~~mal~~practice insurance

Henry Ford Macomb Hospital

HENRY FORD MACOMB HOSPITAL IS REVERIFIED AS A LEVEL II ADULT TRAUMA CENTER

Henry Ford Macomb Hospital has been re-verified by the American College of Surgeons Committee on Trauma (COT) as a Level II-Adult Trauma Center.

"Level II Adult Trauma Center verification is recognition that Henry Ford Macomb Hospital meets or exceeds national standards for delivering safe, high quality and effective trauma care to our patients and community," said Scott Barnes, D.O., medical director of Trauma Services at Henry Ford Macomb. "I'm proud of the people and resources we have dedicated to ensure outstanding trauma care."

Achieving and maintaining verification means that a hospital has voluntarily met criteria that improve the standard of care as outlined by the COT's current Resources for Optimal Care of the Injured Patient manual.

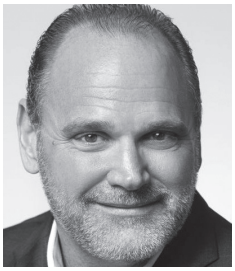
There are five separate categories of verification in the COT's program. Each category has specific criteria that must be met by a facility seeking that level of verification.

Established by the American College of Surgeons in 1987, the COT's Verification/Consultation Program for Hospitals promotes the development of trauma centers that provide not only the hospital resources necessary for trauma care, but also the entire spectrum of care to address the needs of all injured patients. This spectrum encompasses the pre-hospital phase through the rehabilitation process.

NEW MINIMALLY INVASIVE BUNION SURGERY OFFERED

Henry Ford Macomb is the first in Michigan to offer a minimally invasive surgery for patients who suffer from bunions. The new technique causes less damage to the foot, resulting in less pain and faster recovery time.

The procedure employs a special low-speed, high torque drill that cuts through the bone but does not damage the surrounding tissue. While a traditional open surgery requires an 8- to 10-centimeter incision, this new procedure results in two or three 1-centimeter incisions that require only butterfly tape to close. Because there is less scarring, it is also cosmetically more appealing.



Brian Loder, DPM, podiatrist, was one of the first seven surgeons to be trained on the procedure in the United States and now trains other surgeons on the technique. He has performed more than 100 of the minimally invasive procedures in the last year.

"This is without a doubt the most exciting news in foot surgery in several decades," said Dr. Loder. "My patients report much lower pain scores following surgery. Their range of motion and functionality are much better. And they can walk immediately after surgery without the aid of a cast, crutches or walker."

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.*

Ascension Macomb-Oakland Hospital

ASCENSION ST. JOHN HOSPITAL ANNOUNCES NEW PULMONARY FELLOWSHIP PROGRAM

Ascension St. John Hospital now offers a three-year Pulmonary and Critical Care Medicine Fellowship program. The program includes:

- Availability to a variety of patients specific to the experience in Pulmonary and Critical Care Medicine
- 20-bed MICU with complicated cases varying from community acquired sepsis to oncologic patients and patients requiring advanced forms of life support
- 20-bed SICU and a 10-bed CVICU complete a comprehensive exposure to the management of non-medical ICU patients including those undergoing advanced cardiovascular interventions, complex vascular and oncologic surgeries as well as a wide variety of general surgery cases
- The stroke program provides extensive exposure to complex neurosurgical interventions and management of this patient in an ICU setting

Ascension St. John's dedicated Pulmonary floor provides extensive exposure to patients admitted with primary pulmonary diseases such as COPD, asthma, ILD and respiratory failure. Furthermore, the hospitals' Pulmonary Consult service allows extensive exposure to pulmonary complications relevant to the management of oncologic, surgical, trauma, cardiac, renal (including post-transplant patients) and neurologic patients amongst others. For more information, contact Julie Webber, Program Coordinator, at 313-343-3867 or julie.webber@ascension.org.

ASCENSION MICHIGAN HOSTS MEDICAL MISSION AT HOME

The Ascension Michigan Medical Mission at Home, held at St. Joseph Chaldean Catholic Church in Troy on March 23, was an incredible demonstration of our commitment to live our Mission in service to others. Approximately 150 community members were served at Michigan's first Medical Mission at Home event. Our team of physicians, clinicians, volunteers and executives joined with longtime community partners to host the event. The Chaldean American Association of Health Professionals, Chaldean American Ladies of Charity and Arab Community Center for Economic and Social Services were among the partners who provided services, referrals and information. Many of the participants were refugees in need of health and related resources in their new environment. To support the many non-English speaking attendees present, each was assigned a bilingual navigator to assist them in accessing the array of primary and specialty services available. Services provided at no cost included mammogram, cardiovascular screening, hearing and vision screening, diabetes risk screening, mental health information, spiritual care, Medicaid enrollment information and much more. Both the Anthony L. Soave Family Mobile Mammography and Health Screening Center and the mobile cardiovascular screening unit were on site. The church, our external partners and Chaldean community expressed great appreciation for Ascension's commitment to serve the community. It was a day filled with the joy and hope of our ministry.

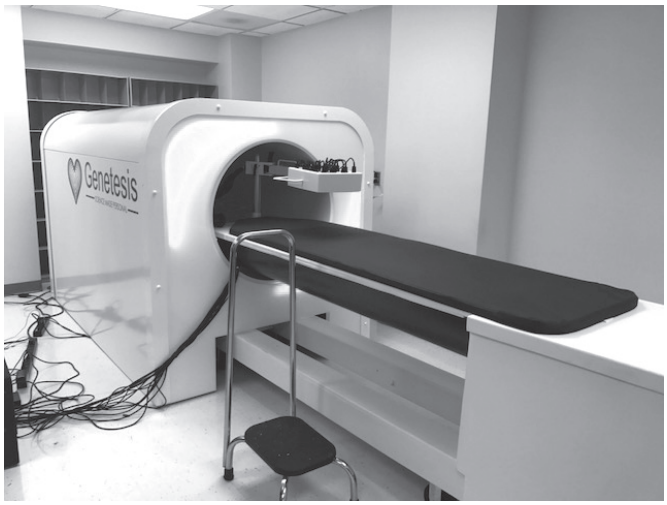
Greeting participants were (l-r): Evone Barkho, Coordinator of Bi-Lingual Community Marketing; Dr. Mazen Alsaqa, Ascension Macomb-Oakland Hospital Internist; Jean Meyer, Ascension Michigan COO; Joseph Cacchione, Ascension Michigan Market Executive and Ascension Medical Group CEO; Terry Hamilton, Ascension Macomb-Oakland Hospital President; and Linda Root, Chief Mission Integration Officer.

ASCENSION ST. JOHN HOSPITAL ED PILOTS NEXT-GEN CARDIAC IMAGING TECHNOLOGY

Genetesis, a medical technology company focused on using bio-magnetic imaging to enable rapid, noninvasive and accurate chest pain triage, has received FDA 510(k) clearance for its cardiac imaging platform. The platform pairs the CardioFlux™ Magnetocardiograph with the integrated Faraday Analytical Cloud™ to measure and visualize the magnetic fields produced by the heart's natural electrical activity.

Ascension St. John Hospital recently completed the investigational study on the technology and the findings were presented by Margarita Pena, MD, FACEP, Medical Director, Clinical Decision Unit, at the American College Emergency Physicians' 2018 Scientific Assembly. The study found that there is great potential for magnetocardiography and CardioFlux to positively impact

the clinical workflow of patients presenting to the ED with chest pain or anginal equivalents, which represent nearly 10 million emergency room visits a year in the U.S. "Building on the initial investigational study at Ascension St. John Hospital, we see the value in magnetocardiography (MCG) along with the 20 years of clinical investigation on the use of MCG and the diagnosis of



myocardial ischemia and coronary artery disease. Moving forward, Ascension St. John plans to collaborate with several sites on the largest multi-center study using MCG, to date," said Edouard Daher, MD, FACC, Director, Cardiac Catheterization Laboratory at Ascension St. John.

MENTAL HEALTH FIRST AID TRAINING FOR ASCENSION MEDICAL GROUP STAFF

In any one year, 18.1% of adults experience a mental health disorder. However, they often do not seek help or delay seeking help and this stigma can be a barrier to receiving assistance. To support its efforts with behavioral health integration, Ascension Medical Group in Southeast Michigan hosted a Mental Health First Aid™ training for its care managers, wellness nurses, and other Population Health Department staff. On February 5, more than 30 associates (pictured) were trained in this evidence-based curriculum by staff from Macomb County Community Mental Health Services and CARE Worklife Solutions. These AMG associates are now certified in Mental Health First Aid and prepared to recognize symptoms of mental health problems, offer and provide initial help, and guide a person toward appropriate treatments and other supportive help.

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Medical Records of Retired Physicians

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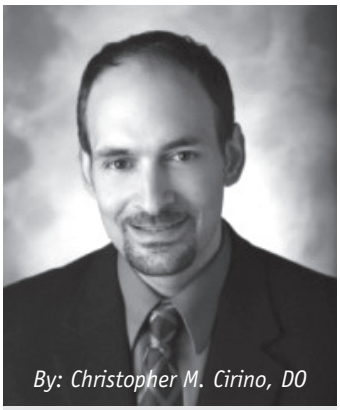
Concerns about U.S. Measles Outbreak

A recent poll by The Doctors Company received 9,459 responses to the question: How concerned are you as a healthcare provider about the recent U.S. measles outbreak? Some 43 percent responded that they are very concerned. There are significant reasons for this level of concern.

The number of measles cases reported in the United States in 2018 (372) was three times higher than that of the preceding year, and currently, only the second month into 2019, there are more than 100 reported cases of measles. With an estimated worldwide 30 percent increase of measles cases over the last few years, it is frustrating to think that this vaccine-preventable illness, which can be associated with serious consequences, including death, is resurging. Do we as healthcare workers really need to be concerned about measles?



By: Christopher M. Cirino, DO

> *The number of measles cases reported in the United States in 2018 (372) was three times higher than that of the preceding year.*

In this global stage, what goes on in one country really does affect the entire world. The highest caseloads of measles worldwide in 2018 were seen in India, Ukraine, and the Philippines. We are now in a time when you can cross the globe in as little as 18 hours — in less than the typical time it takes for an infected person to develop the telling measles rash. A person can acquire the infection from a high-prevalence country, spread the infection to others in the closed quarters of an airplane, and return to a low-prevalence country with a silent stowaway, only to then go back to a social circle with similarly low vaccination rates — and this is precisely what is happening.

Measles, which is one of the most transmissible infectious diseases (with an attack rate of 90 percent), has always been regarded as a "canary in the coal mine" for the status of vaccine programs both nationally and worldwide. Breakdowns in the vaccine chain have typically been seen in countries beset by war and political turmoil, which often abandon vaccine programs, leaving children unvaccinated or incompletely vaccinated. There has also been a growth in the level of distrust and "alternate facts" about vaccine safety and need, specifically regarding the MMR and MMRV, and this spread has been kindled by social media. Unfortunately, this distrust isn't something that can easily be mitigated by education initiatives.

It might be easier for some to decline a vaccination, because the risk of death from measles is one in 1,000. Though sadly, with the estimated caseload of measles each year worldwide, more than 100,000 children likely die from measles each year. The medical field is steadfast on the principal of reducing the risk of death from a vaccine-preventable illness, and concerted vaccination programs were able to eradicate a much more harmful viral illness — smallpox — which had a death rate of one in three. Though until we can bridge the rift between public health goals and anti-vaccination sentiment, and bolster the more highly prevalent countries' vaccination programs, we should all expect to see more cases of measles, mumps, and a myriad of other vaccine-preventable illnesses coming to a clinic near you.

Doctor Cirino works in Portland, OR and specializes in infectious diseases. Doctor Cirino is affiliated with Portland Adventist Medical Center and Vibra Specialty Hospital and is the health officer at the Marion County Department of Public Health. Doctor Cirino has also written a blog on this topic at his site https://yourhealthforumbydrcirino.org

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 considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

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New Members

ALLEN L. BABCOCK, MD

Orthopaedic Surgery - Board Certified

Medical School: Loyola University of Chicago-Stritch School of Medicine, 1970. Post Graduate Education: William Beaumont Hospital, completed in 1977. Hospital Affiliations: Troy Beaumont, Ascension Crittenton. Currently practicing at Center for Advanced Orthopedics & Sports Medicine, 3100 Cross Creek Parkway, # 200, Auburn Hills, MI 48326, ph. 248-377-8000, fx. 248-377-2929, website www.centerforao.com

ROBERT A. GINNEBAUGH, MD

Anesthesiology - Board Certified

Medical School: Wayne State University School of Medicine, 2013. Post Graduate Education: Brigham and Women's Hospital (MA), completed in 2018. Hospital Affiliation: Henry Ford Macomb. Currently practicing at Macomb Anesthesia PC, 15855 19 Mile Rd., Clinton Township, MI 48038, ph. 586-263-2300.

Nonopioid Directive Form Helps Fight Opioid Epidemic by Allowing Patients to Notify Health Professionals They Don't Want Opioids

Patients can now fill out a state form that directs health professionals and emergency medical services personnel to not administer opioids to them.

In April, the Michigan Department of Health and Human Services (MDHHS) made the nonopioid directive form available to the public on its website in response to a new state law. The nonopioid directive is part of the State of Michigan's multifaceted plan to address the opioid epidemic.

"This law helps ensure nonopioid options to pain management are considered in the medical treatment of Michigan patients," said Doctor Debra Pinals, MDHHS medical director of Behavioral Health and Forensic Programs. "Providing this supportive tool for patients to notify their health professionals that they are seeking alternatives for pain treatment is critically important for those who are most at-risk of misusing opioids, including those with a history of an opioid disorder."

A link to the directive form can be found under "Additional Resources" at the bottom of the "Find Help Page" on Michigan's Opioid Addiction Resources website, www.michigan.gov/opioids, along with other information.

The nonopioid directive can be filled out by the patient or a person's legal guardian or patient advocate. Once submitted, the directive must be included in the patient's medical records. There are exceptions in the law, such as a provision that a prescriber or a nurse under the order of a prescriber may administer an opioid if it is deemed medically necessary for treatment.

Public Act 554 of 2018 amended the Public Health Code to provide for the form and required MDHHS to make it available on its website by April 3, 2019.

Michigan has been significantly affected by the national opioid epidemic. The number of annual opioid-related overdose deaths in the state have more than tripled since 2011, from 622 to 2,053. As part of the state-government-wide plan to address the issue, MDHHS has developed an action plan that is focused on prevention, early intervention and treatment.

The nonopioid directive form can be found at https://www.michigan.gov/documents/

Wearable Medical Devices Give Abundant Data - and Risks

By: Miranda Felde, MHA, CPHRM, Vice President, Patient Safety and Risk Management

SINCE 2013, THE NUMBER OF U.S. CONSUMERS TRACKING THEIR HEALTH DATA WITH WEARABLES HAS DOUBLED.[1] And that number continues to rise: During the third quarter of 2018, the wearables market saw a nearly 60 percent increase in earnings over the prior year.[2]

Wearables are electronic devices worn on the body, often like a watch. Wearables can track patient data like heart rate, blood pressure, or blood glucose. They can also track activity level, e.g., counting steps.

Promoters of wearables say that they could provide physicians with abundant data when caring for patients with chronic health issues. They also predict that combining wearables and gamification - e.g., competing with family members to see who can "score" the most steps in a day - may lead to improved health and better health outcomes.

However, skeptics question whether gamification will really lead to healthier behaviors long-term. And questions abound about what to do with wearables' data and how to protect it. Wearables bring promise, but also real risks for patient safety and physician liability.

Benefits of Wearables

Promoters of wearables believe wearables will drive the transition to intelligent care, whereby physicians have access to more data - in which they can identify actionable components. Florence Comite, MD, a New York endocrinologist who describes wearables as "almost like magic," uses data from wearables to tailor her interventions for patients with chronic conditions.[3]

Wearables can help patients take action, too. In one recent study, diabetes patients using a wearable app showed randomized controlled trial results comparable or superior to patients taking diabetes medications.[4]

Promoters of such digital strategies hope that they will encourage healthy behaviors while requiring fewer office visits purely for monitoring purposes, thereby reducing healthcare costs while improving patient experience and engagement. For instance, David Rhew, MD, chief medical officer for Samsung, hopes that wearables can help patients move to the highest level of patient activation, Level 4:[5]

The Four Levels of Patient Activation

- Level 1: Predisposed to be passive. "My doctor is in charge of my health."
- Level 2: Building knowledge and confidence. "I could be doing more."
- Level 3: Taking action. "I'm part of my healthcare team."
- Level 4: Maintaining behaviors, pushing further. "I'm my own advocate."

Some apps promote healthy behaviors with gamification.[6] For instance, a user might compete with family or friends to take the most steps each day, either informally or through an organized group. Harvard professor Ichiro Kawachi, PhD, wrote in JAMA Internal Medicine that this is "an opportunity for clinicians to turn health promotion into an engaging, fulfilling and fun activity."[7] Sponsors hope that such groups can promote accountability, responsibility, and mindfulness about activity and health conditions.

Skepticism about Wearables

It is too soon to say whether wearables will increase healthy behaviors and/or reduce office visits, thus lowering healthcare costs. Some studies have found that wearable devices have no advantage over other forms of goal tracking or social support in helping people meet their health and fitness goals.[8] A 2016 study from the University of Pittsburgh, for instance, found that "young adults who used fitness trackers in the study lost less weight than those in a control group who self-reported their exercise and diet."[9]

Risks of Wearables

Though each device has its pros and cons, all wearables generate concerns for physicians, including:

- Poor data quality: Data from wearables may or may not be reliable enough for medical use.[10]
- Data fixation: Patients may fixate on one number - steps per day, for instance - at the expense of other health variables, such as their diet, sleep habits, etc.
- Lack of interoperability with electronic health records (EHRs): If a patient's wearable cannot stream data to the patient's EHR, then how can the physician's practice securely acquire the data?
- Data saturation: Physicians receiving patient data from wearables risk being soaked by a data fire hose.[11] Physicians need a plan and a process to determine what measurements are relevant to a given patient.
- Unclear physician responsibilities for collecting, monitoring, and

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.

protecting data: HIPAA applies to patient data collected by physicians,[12] but differing state laws mean that a physician's specific responsibilities for monitoring and protecting patient data vary by location.

- Lack of data security - and liability for physicians: Wearables are subject to cyberattack. In addition to presenting obvious risks to patient safety, this may also present liability risks to physicians - who may be expected to notify patients of recalls issued for their wearables.[13]

Next Steps

As more and more physicians are accepting – or requesting – their patients' data from wearables, questions include: How can we tell when data from wearables is accurate? When it's actionable? When it's secure?

Certainly, physicians interacting with data from wearables should independently confirm that data before changing a patient's care, and should store data from wearables securely.

For help implementing remote patient monitoring in your practice, see the American Medical Association's (AMA's) Digital Health Implementation Playbook.

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UPCOMING EVENTS

MAY 16 & 17 MSMS Spring Scientific Meeting, at the Double Tree by Hilton in Dearborn. For more information visit www.msms.org/eo

MAY 16 MSMS conference "Documentation for MACRA & HCC", at the Double Tree by Hilton in Dearborn, 1 pm - 4 pm. For more information or to register visit www.msms.org/eo

MAY 16 "Applying the Integrated Care Approach: Practical Skills for the Consulting Psychiatrist and Primary Care Providers", at the Double Tree by Hilton in Dearborn, 12:30 pm - 3:45 pm. Credits: 3 AMA/PRA Category 1 Credits, cost $135 for MSMS members ($185 for non-members). For more information or to register visit www.msms.org/eo

AUGUST 9 2019 Henry Ford Sinus & Nasal Symposium, at the Henry Ford Hospital Education & Resource Building 2055 (2799 W. Grand Blvd. in Detroit), 8 am - 4:30 pm. Credits: 6.75 AMA/PRA Category 1 Credits. For more information or to register visit https://henryfordsinusnasalsymposium.com/

OCTOBER 23 - 26 MSMS Annual Scientific Meeting, at the Sheraton Detroit in Novi. For more information visit www.msms.org/eo

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STOPPING THE SCOURGE OF SOCIAL MEDIA MISINFORMATION ON VACCINES

By: Andis Robeznieks, Senior News Writer, American Medical Association

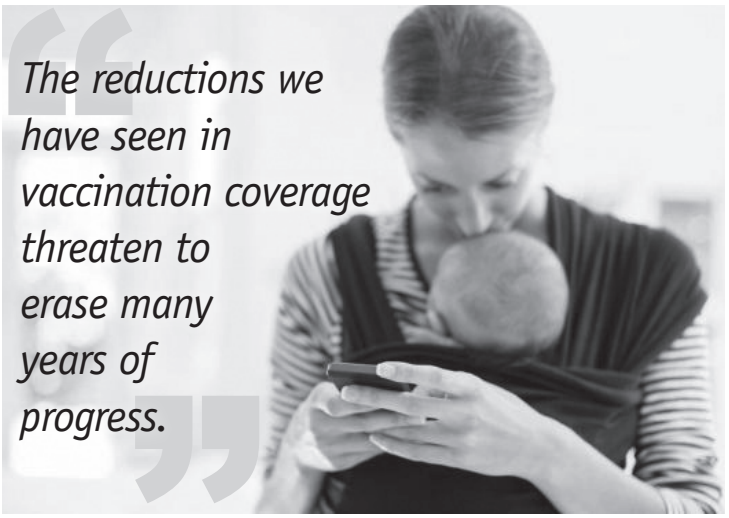
It is common that patient searches for information and products related to the word "vaccine" yield top results pointing to harmfully inaccurate information about immunization safety. This place of prominence given to medical disinformation is deeply troubling to America's physicians, especially amid alarming new reports regarding measles, tetanus and other vaccine-preventable conditions.

The AMA sent a letter to top executives at Amazon, Facebook, Google, Pinterest, Twitter and YouTube urging them to do even more to stem the "proliferation" of "health-related misinformation" that has helped vaccine-preventable diseases to reemerge.

"We applaud companies that have already taken action but encourage you to continue evaluating the impact of these policies and take further steps to address the issue as needed," AMA Executive Vice President and CEO James L. Madara, MD, wrote in the letter to the social media and digital technology executives. "The overwhelming scientific evidence shows that vaccines are among the most effective and safest interventions to both prevent individual illness and protect public health."

Dr. Madara noted that, when immunization rates are high, children who are too young to be vaccinated and others whose health conditions prevent them from being vaccinated, are protected from disease because exposure is so limited. These conditions include allergies to vaccine components, HIV infection and having a compromised immune system as a result of receiving chemotherapy cancer treatment.

The impact of lower vaccination rates has been clear. The World Health Organization named vaccine hesitancy among the top 10 threats to global health in 2019. The Centers for Disease Control and Prevention (CDC) reported that there have been at least 228 individual measles cases confirmed in 12 states between Jan. 1 and March 7, 2019, with 71 of those traced to Clark County in Washington. Four confirmed cases in Oregon were linked to the Clark County outbreak.



In another report out of Oregon, the CDC told of an unvaccinated 6-year-old boy who contracted tetanus and required 57 days in the hospital and almost $1 million in care before being released. Upon release, his parents still declined giving him recommended vaccinations, according to the CDC.

"The reductions we have seen in vaccination coverage threaten to erase many years of progress as nearly-eliminated and preventable diseases return, resulting in illness, disability and death," Dr. Madara wrote. "In order to protect our communities' health, it is important that people be aware not just that these diseases still exist and can still debilitate and kill, but that vaccines are a safe, proven way to protect against them."

Spreading vaccine safety message

To help spread this message and to counter misinformation campaigns, the National Academies of Sciences, Engineering and Medicine created a website displaying the overwhelming evidence that vaccines are safe. This message was repeated again in the Annals of Internal Medicine, which published a Danish study, "Measles, Mumps, Rubella Vaccination and Autism: A Nationwide Cohort Study," that followed almost 660,000 children and found no connection between the measles, mumps, rubella (MMR) vaccine and autism.

"The study strongly supports that MMR vaccination does not increase the risk for autism, does not trigger autism in susceptible children, and is not associated with clustering of autism cases after vaccination," the researchers wrote. "It adds to previous studies through significant additional statistical power and by addressing hypotheses of susceptible subgroups and clustering of cases."

Ending nonmedical vaccine exemptions

In addition to engaging digital and social media executives, the AMA has been active in state legislatures supporting bills seeking to eliminate non-medical exemptions for required childhood vaccines in Maine, Oregon and Washington. The AMA is also opposing an Arizona bill that would discourage adherence to recommended vaccine schedules.

California, Mississippi and West Virginia are the only states that do not allow parents to opt out of vaccinating their children for personal, philosophical or religious reasons.

AMA STANDS UP FOR ACA PATIENT PROTECTIONS IN FEDERAL COURT

To help defend and maintain the significant coverage gains patients have benefited from because of the Affordable Care Act (ACA), the AMA filed an amicus brief opposing a ruling that struck it down.

In Texas v. United States, Federal Northern Texas District Judge Reed O'Connor ruled in December that the individual mandate to carry health insurance was unconstitutional after the 2017 Congress changed the tax penalty to zero dollars and so, therefore, was the rest of the law. The U.S. Department of Justice told the 5th U.S. Circuit Court of Appeals last week that it agreed with the entirety of that decision and would no longer defend the ACA in court.

If the decision is allowed to stand, 20 million people could lose their coverage and the ACA would be discarded without a plan ready to replace it.

"The district court ruling that the individual mandate is unconstitutional and inseverable from the remainder of the ACA would wreak havoc on the entire health care system, destabilize health insurance coverage, and roll back federal health policy to 2009," said AMA President Barbara L. McAneny, MD. "The ACA has dramatically boosted insurance coverage, and key provisions of the law enjoy widespread public support. The district court's decision to invalidate the entire ACA should be reversed."

The brief describes "the havoc that striking the entire ACA would cause to the entire U.S. health care system" and also demonstrates "that, under proper analysis, the individual mandate is severable from the remaining provisions of the ACA."

The brief also shows that Congress intended all other ACA health care provisions to stay in force when it eliminated the individual mandate tax penalty. Those provisions include:

- Subsidies to low-income Americans who purchase health insurance on exchanges established under the ACA.
- Payments to states for voluntary expansion of their Medicaid programs.
- Required coverage of "essential health benefits" and preventive services.
- Required coverage of people with preexisting conditions.

"Nothing indicates that the 2017 Congress intended these provisions to be struck down because the tax on non-compliance with the individual mandate was reduced to zero," the brief says. "Rather, these provisions are fundamental to the delivery of high-quality, affordable care in this country."

No plan for replacing the ACA has been publicly released. The Democrats recently unveiled a package of bills aimed at lowering individual market premiums, expanding ACA navigator and outreach activities, and funding to help states establish their own individual insurance marketplaces.

"The AMA believes that these bills would help to reduce consumers' health care costs and improve their access to high quality insurance coverage," AMA Executive Vice President and CEO James L. Madara, MD, wrote in a letter to leaders of the House Energy and Commerce Committee.

Republicans have not yet publicly released a plan to replace the ACA, but Sen. Susan Collins, R, Maine, wrote a letter to Attorney General William Barr explaining why she disagreed with the DOJ action, which she said puts at risk several "critical consumer provisions."

Collins wrote that it was "implausible" that Congress intended for these protections to be eliminated when it reduced the individual mandate penalty to zero.

"If Congress had intended to eliminate these consumer protections along with the individual mandate, it could have done so," she wrote. "It chose not to do so. Rather than seeking to have the courts invalidate the ACA, the proper route for the administration to pursue would be to propose changes to the ACA or to once again seek its repeal."

The AMA's highest priority is that the millions who have gained coverage under the ACA do not lose it. It has also acknowledged that the ACA has problems that need to be fixed, such as gaps in coverage.

The organizations joining the AMA in the brief are the: American Academy of Allergy, Asthma and Immunology, American Academy of Family Physicians, American Academy of Pediatrics, American Association of Child and Adolescent Psychiatry, American Association of Public Health Physicians, American College of Correctional Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Radiation Oncology, American Geriatrics Society, American Medical Women's Association, American Osteopathic Association, American Psychiatric Association, American Society of Hematology, American Society for Metabolic and Bariatric Surgery, GLMA: Health Professionals Advancing LGBTQ Equality, and the Renal Physicians Association.

SURPRISE BILLING: 7 PRINCIPLES TO FIX A BROKEN SYSTEM

Overly narrow and inadequate provider networks are resulting in cost-shifting from insurance companies to patients who are being charged with unanticipated medical bills.

Insurers have been calling this situation "surprise billing," and Congress is exploring what can be done to protect patients. The AMA has offered guidance into doing so.

The AMA joined with more than 100 specialty and state medical societies and other health care organizations in a letter to leaders of the Senate and House committees of jurisdiction expressing their concerns on this issue.

"Health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, pharmacies, and other providers as one mechanism for controlling costs," the letter states.

Even patients who research which physicians and hospitals are in their insurance network may receive unanticipated out-of-network bills "because they had no way of knowing and researching in advance all the individuals who are ultimately involved in their care," the letter adds.

The AMA and the other organizations detail seven principles for Congress to consider when developing legislation that seeks to protect patients from costs their insurance will not cover.

Insurer accountability. Strong oversight and enforcement of network adequacy is needed from both federal and state governments. This includes an adequate ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times.

Other aspects of insurer accountability include having accurate provider directories. The groups also said patients should be protected from unexpected emergency-care bills in instances where they were unable to accurately self-diagnose if the worrisome symptoms they had were due to an emergency medical condition or not.

Limits on patient responsibility. Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills.

Transparency. Patients who choose to obtain scheduled care from out-of-network providers should be told by those providers prior to receiving care about anticipated charges. Insurers should tell how much they will cover.

Universality. Legislation to address unanticipated out-of-network bills should apply to plans governed by the Employee Retirement Income Security Act of 1974.

Set benchmark payments. Legislative caps on payment for physicians treating out-of-network patients should be avoided. But, if pursued, payment guidelines or limits should reflect actual charge data for the same service in the same geographic area. They should not be based on Medicare rates, which have become increasingly inadequate in covering overhead costs.

Dispute resolution. There should be a dispute-resolution process for circumstances where the minimum payment standard is insufficient due to the complexity of the patient's medical condition.

Don't put patients in the middle. Patients should not be burdened with negotiations. Physicians should be given direct payment or assignment of benefits from the insurer.

This balanced approach protects patients, improves transparency, promotes access to appropriate care, and "avoids disincentives" to negotiating network participation contracts in good faith, the organizations told committee leaders.

APPELLATE COURT CASE PUTS PEER-REVIEW PROTECTIONS IN DANGER

Physicians in Michigan are in danger of having peer-review documents become discoverable in court cases if a trial court ruling isn't reversed on appeal.

The Litigation Center of the American Medical Association and State Medical Societies and Michigan State Medical Society recently filed a friend-of-the-court brief urging the Michigan Court of Appeals to reverse the lower court decision that takes away the assurance that any knowledge or documents provided during the peer review process will be confidential.

If peer review isn't protected, the "purpose and effectiveness" of the privilege will be undermined and physicians won't be as willing to participate in reviews that have been crucial in reducing morbidity and mortality and improving patient care, the AMA Litigation Center told the appellate court in its brief filed in Dwyer v. Ascension Crittenton Hospital.

The hospital appealed the case after a trial court judge ordered a Michigan hospital had to provide parts of a physician's credentialing file to the plaintiff in a medical liability lawsuit.

The trial court said the file must be made available to the plaintiff because the privilege only applies to documents in the committee's deliberations, discussions, evaluation and judgment; when a member of the peer review entity "generated" an email and sent it directly to a peer review entity member; or when it was prepared at the request of a peer review entity member.

But the several decades of law on the

subject do not limit the privilege, the AMA Litigation Center brief argues. "To the contrary," the brief says, "Michigan's peer review privilege has historically spanned the bounds of the peer review process."

Safety gains exceed plaintiff need

The amicus brief concludes that the trial court rewrote statutes designed to protect the materials from being discoverable during litigation. It notes that the judge opined that "if all materials viewed by peer review committees were deemed undiscoverable, a hospital could never be held accountable for any negligent act within the purview of the committee."

But that rationale is wrong, the AMA Litigation Center tells the appellate court.

Hospitals can be held liable - and are regularly held liable without opening up these documents, the brief says. With the exception of the contents of the peer-review file and deliberations of the peer-review committee that are privileged, plaintiffs can use the same discovery mechanisms generally available to plaintiffs in other lawsuits.

As for treating peer review differently, "the legislature has determined that the importance of fostering a candid evaluation of the practices within the hospital outweighs all other competing considerations," the brief states. It goes on to note that the trial court wasn't "authorized to disturb the balance reached by the legislature with respect to this issue."

Laws support broad protection

Because lawmakers recognize the importance of confidentiality, Michigan's peer-review privileges are written into the law so that physicians and others involved in patient safety can conduct candid evaluations and discussions key to improving future care, amici tell the court.

Michigan law directed the state's hospital administrators to create peer review committees. And the state enacted a law that "protects peer review activities from intrusive public involvement and from litigation," the AMA Litigation Center brief points out quoting legal precedent on the issue.

The brief also shows how the courts have repeatedly held that the peer review privilege is broad and that the Legislature intended to keep peer review records from discovery.

In asking that the lower court decision be reversed, the brief says the trial court "disregards the plain language of these clear and unambiguous statutes, imposing distinctions, conditions and requirements upon exercise of the privilege that are not expressed in the statutes."

NEW ICD-10 CODES WILL HELP PHYSICIANS TACKLE SOCIAL BARRIERS TO CARE

A new collaboration between the AMA and UnitedHealthcare will work to address the social and environmental factors that affect patients' health by standardizing data collection on their social determinants of health (SDOH) to help address individuals' unique needs that often go unmet.

The two organizations are supporting the creation of 23 new ICD-10 codes related to social determinants. ICD-10 codes are typically used to record diagnosis, symptoms and procedures. Social factors that the new codes would capture include:

- Access to nutritious food.
- Adequate and safe housing.
- Available transportation.
- Financial ability to pay for medications.
- Financial ability to pay for utilities.
- Caregiver needs.

"The AMA is excited to work with UnitedHealthcare through the continuing efforts of our Integrated Health Model Initiative™ (IHMI) to foster collaboration around innovative data and technology-driven processes for incorporating social determinants of health into routine medical care," said Tom Giannulli, MD, IHMI chief medical information officer. "The collaboration reinforces the importance of social and environmental factors in patient care, and will shape IHMI's efforts to support clinical decisions with useful and valid data to achieve broad improvements in health and greater health equity."

The IHMI group is a collaborative effort across health care and technology stakeholders that seeks to improve patient health outcomes by empowering physicians with the clinically valid health care data

needed to make informed clinical decisions. IHMI supports a market-informed, continuous learning environment to enable interoperable technology solutions and care models that evolve with real-world use and feedback.

The effort is a recognition that unmet social needs have a significant impact on a person's health and well-being. It aims to collect the self-reported data in a manner that minimizes variation to solve problems caused by non-standardized data and data quality issues.

Because UnitedHealthcare, a UnitedHealth Group company, directly contracts with more than 1.3 million physicians and other health care professionals they have an existing network with the capacity to take this mission on.

"By working together to leverage data, technology and the incredible expertise of our network physicians, we can more effectively address the social factors that limit access to health care," said Bill Hagen, UnitedHealthcare clinical services president.

Providing nonmedical services

The new codes will also trigger referrals to local and national social and government services to address the patient's self-reported social barriers to better health.

Some 560,000 referrals were made in 2017 for individuals enrolled in UnitedHealthcare Medicare Advantage plans, the company reported. These referrals connected people to transportation, nutrition assistance and social programs that reduce isolation, UnitedHealthcare reported.

Nearly 80 percent of the factors that affect a person's health are non-medical in nature, according to the Robert Wood Johnson Foundation. By capturing standardized data on such elements as employment, isolation, veteran status and other social determinants, the AMA-UnitedHealthcare collaboration is poised to address non-medical barriers to better health.

Privacy to be protected

The proposed codes were presented at a March 6 meeting of the Centers for Medicare & Medicaid Services' (CMS) ICD-10 Steering and Maintenance Committee and are out for public comment. If CMS adopts the codes, they will apply to fiscal 2020, which runs from Oct. 1, 2020 through Sept. 30, 2021.

UnitedHealthcare said it does not seek to add to physicians' administrative burdens and noted that the 23 new codes would not significantly grow the ICD-10 database of 68,000 codes. It also noted that physicians would not be reimbursed for adding the new codes on a claim for payment.

Some of the data collected qualifies as protected health information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA). UnitedHealthcare said it will follow HIPAA regulations and industry standards regarding sharing PHI.

The AMA plans to review the model in several areas, including compatibility with Fast Healthcare Interoperability Resources, the burden on physicians and other health professionals, and potential social bias.

AMA policy supports efforts to integrate training in social determinants of health in the medical school curriculum and support payment-reform policy proposals that encourage screening for social determinants of health and referral to community-support systems.

UnitedHealthcare stated that one of its long-term goals is to build support for reimbursement of nonclinical support by standardizing fair market value for these services.

5 WAYS NEW TITLE X RULE THREATENS PATIENT-PHYSICIAN RELATIONSHIP

Calling the Trump administration's changes to the Title X program "the wrong prescription for America," the AMA has filed a lawsuit to block the implementation of those changes arguing that they would violate the sanctity of the patient-physician relationship by dictating the content of their conversations.

"As physicians, we know that any law or regulation that interferes with or limits our obligation to talk openly with our patients about their health is antithetical to quality care and undermines the patient-physician relationship," AMA President Barbara L. McAneny, MD, wrote in an AMA Leadership Viewpoints column. "The AMA intends to protect the patient-physician relationship anywhere it is threatened."

AMA Senior Vice President and General Counsel Brian Vandenberg explained in a Facebook Live interview the harm the

new rule could do to patient-physician relationships that rely on trust.

"What the AMA believes, first and foremost, is that the patient-physician relationship is founded on trust and needs to be honored as sacred," Vandenberg said. When the government injects itself into the exam room, trust is eroded and that's a slippery slope."

Vandenberg acknowledged that, historically, the AMA acting as lead plaintiff in a lawsuit against the government is a "somewhat rare action." But, because - with the new rule - the government is not only limiting what a physician can say to a patient, it is also scripting what they must say, it has crossed a line "so significantly, so profoundly," that the AMA must step in.

The AMA seeks to have the rule declared unconstitutional. The AMA is seeking preliminary and permanent injunctions against implementing the rule, which is set to take effect this May, Vandenberg said.

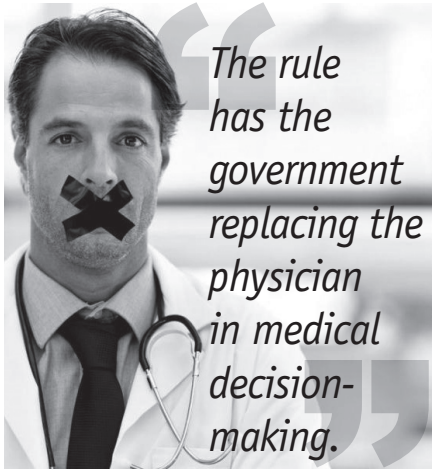
Rule blocks a trusted entry point

The AMA's complaint describes the patient-physician relationship as "sacrosanct," and also notes that the Title X program often serves as "the most trusted entry point" and "gateway to all other health care" for many low-income women. Because of this, Title X health centers frequently facilitate a crucial touch and the potential for other referrals that otherwise might not have happened.

The lawsuit also argues that the new rule threatens to destroy what has been an "extraordinarily successful" program that has helped women avoid an estimated 800,000 unintended pregnancies and yielded vast benefits in terms of prevention and early detection of cervical cancer and sexually transmitted infections.

This is just one way the new rule would have a negative impact on the patient-relationship. Other examples cited in the lawsuit include:

It creates a conflict of interest. "It will mandate that the speech of physicians and other health care professionals be tailored according to what the government may favor, rather than according to the interests of the patient, best medical practices, or accepted medical ethics," the lawsuit states. "If allowed to stand, the Final Rule will reinforce a dangerous idea – that physicians and others in the medical profession are to place the interests of government above the interests of their patients."



The rule requires physicians to disregard patient wishes by banning abortion referrals while mandating prenatal referrals. "Title X providers must not tell pregnant patients how and where they can access abortion safely and legally, but they must provide that information as to prenatal care – again, regardless of what a patient actually wants, or what is in the patient's best medical interest," the lawsuit states.

The rule torpedoes a "fundamental tenet of high quality medical care," which is that physicians must be able to have frank and confidential communications with patients. Leonard Nelson, director of the Litigation Center of the AMA and State Medical Societies, noted on the Facebook Live interview that the rule prohibits physicians from giving straightforward answers to patients' questions. If asked to provide a referral to an abortion provider, Nelson said the rule calls for providing patients with a list of health care providers who may or may not provide abortion services.

"The physician has to give a list that basically sends the patient on a wild-goose chase," Nelson said. "That puts a real burden on their ability to find these services and puts a huge impediment on their confidence in the health care system and in the physician-patient relationship."

The rule has the government replacing the physician in medical decision-making. The rule permits referral in limited instances such as cases of rape or incest or "medically necessary" referrals or "documented emergency care reasons."

"In sum, the Final Rule not only limits what medical professionals can and cannot say to patients, but also attempts to take the place of the physician by dictating, without ever examining a patient, what is and is not a medical emergency, medically necessary, or comprehensive medical care," the lawsuit argues.

The rule creates barriers to care and its gag clauses will have harmful consequences to patients. "Forcing Title X practitioners to conceal or distort health care options will inevitably lead to an erosion of patient trust in their providers and the health care system as a whole," the lawsuit states. "The patient-provider relationship is founded on trust. Once that trust is gone, patients may withhold important information because they no longer feel comfortable sharing it, or simply forgo needed care altogether."

More resources on the changes to the Title X program, the AMA lawsuit and the fight to protect physicians' freedom speech can be found on the AMA website. Physicians are also encouraged to share their opinions on social media using #LetDocsSpeak.

DEA Warns of Alarming Increase of Scam Calls

The Drug Enforcement Administration urges its DEA-registered practitioners and members of the public to be cautious of telephone calls from criminals posing as DEA or other law enforcement personnel threatening arrest and prosecution for supposed violations of federal drug laws or involvement in drug-trafficking activities.

DEA continues to receive reports from practitioners and the general public, alike, indicating that they have received calls threatening legal action if an exorbitant fine is not paid immediately over the phone. The callers typically identify themselves as DEA personnel and instruct their victims to pay the "fine" via wire transfer to avoid arrest, prosecution and imprisonment.

The reported scam tactics are continually changing, but often share many of the following characteristics:

- Callers use fake names and badge numbers or, alternatively, names of well-known DEA senior officials.
- The tone of calls is urgent and aggressive; callers refuse to speak or leave a message with anyone other than the person for whom they are calling.
- Callers threaten arrest, prosecution and imprisonment, and in the case of medical practitioners, revocation of their DEA numbers.
- Callers demand thousands of dollars via wire transfer or, in some instances, in the form of untraceable gift cards taken over the phone.
- Callers falsify the number on caller ID to appear as a legitimate DEA phone number.
- Callers will often ask for personal information, such as social security number or date of birth.
- When calling a medical practitioner, callers often reference National Provider Identifier numbers and/or state license numbers. They also might claim that patients are making accusations against the practitioner.

It's important to underscore that DEA personnel will never contact practitioners or members of the public by telephone to demand money or any other form of payment. DEA will not request any personal or sensitive information over the phone. Notification of a legitimate investigation or legal action is made via official letter or in person.

Impersonating a federal agent is a violation of federal law.

Anyone receiving a telephone call from a person purporting to be a DEA special agent or other law enforcement official seeking money should refuse the demand and report the threat using the online form or by calling 877-792-2873. Reporting scam calls will greatly assist DEA in investigating and stopping this criminal activity. Any urgent concerns or questions, including inquiring about legitimate investigations, should be directed to the local DEA field division.

To report scam activity online, visit https://apps.deadiversion.usdoj.gov/esor/spring/main?execution=e1s1.

For contact information for DEA field divisions, visit https://www.dea.gov/domestic-divisions.

May/June 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 March, 2019***

	2019	2018	2017	2016	2015
AMEBIASIS	0	0	0	1	0
BLASTOMYCOSIS	0	1	0	1	0
BOTULISM (FOODBORNE)	0	0	0	0	0
BOTULISM (INFANT)	0	0	0	0	0
BRUCELLOSIS	0	0	0	0	0
CAMPYLOBACTER	23	136	120	96	79
CHICKENPOX	31	40	31	33	32
CHLAMYDIA	906	3,670	3,598	3,185	2,736
COCCIDIOIDOMYCOSIS	0	4	2	2	2
CREUTZFELDT JAKOB	0	2	2	2	2
CRYPTOCOCCOSIS	1	4	1	1	1
CRYPTOSPORIDIOSIS	1	12	6	10	1
CYCLOSPORIASIS	0	1	12	2	0
DENGUE FEVER	0	0	0	1	1
DIPHTHERIA	0	0	0	0	0
EHRLICHIOSIS	0	0	0	3	0
ENCEPHALITIS PRIMARY	1	2	4	1	2
ENC POST OTHER	2	2	1	1	1
FLU-LIKE DISEASE	7,508	23,444	28,172	21,747	27,943
GIARDIASIS	4	9	20	23	17
GONORRHEA	266	1100	946	801	522
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	2	10	9	10	4
H. FLU INVASIVE DISEASE	1	10	21	14	11
HEMOLYTIC UREMIC SYN.	0	0	0	0	0
HEPATITIS A	1	34	201	9	5
HEPATITIS B (ACUTE)	0	4	5	9	6
HEP B (CHRONIC)	26	102	108	110	125
HEPATITIS C (ACUTE)	4	31	49	31	16
HEP C (CHRONIC)	163	848	898	931	673
HEPATITIS D	0	1	0	0	0
HEPATITIS E	0	1	0	0	0
HISTOPLASMOSIS	1	3	0	5	5
HIV^	11	75	69	57	64
INFLUENZA	3101	7,567	4,136	2,164	1,143
KAWASAKI SYNDROME	1	3	5	5	10

	2019	2018	2017	2016	2015
LEGIONELLOSIS	5	101	56	34	25
LISTERIOSIS	0	3	3	1	1
LYME DISEASE	1	7	5	3	5
MALARIA	0	2	2	2	2
MEASLES	0	0	1	0	0
MENINGITIS VIRAL	4	60	44	43	60
MENINGITIS BACTERIAL/BACTEREMIA *(EXCLUDING N. MENINGITIDIS)*	2	16	11	9	10
MENINGOCOCCAL DISEASE	0	0	0	1	1
MUMPS	0	1	3	2	0
PERTUSSIS	2	47	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	7	82	75	78	82
SHIGELLOSIS	4	10	46	50	22
STEC**	0	24	10	7	9
STREP DIS, INV, GRP A	12	46	32	31	27
STREP PNEUMO, INV + DR	14	54	45	55	52
SYPHILIS	12	132	84	79	108
SYPHILIS CONGENITAL	0	0	1	0	2
TETANUS	0	0	0	0	0
TOXIC SHOCK SYNDROME	0	1	0	0	1
TUBERCULOSIS	1	5	10	11	6
TULAREMIA	0	0	0	0	0
TYPHOID FEVER	0	0	0	0	1
VIBRIOSIS	0	2	0	1	0
VISA	0	0	1	0	0
WEST NILE VIRUS	0	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.

15-Apr-19

^ Previously reported as "AIDS"

*** 2018 totals are provisional at this time.