2015 TRENDS IDENTIFICATION REPORT

AAMSE

2015 Task Force Members

Ryan Adame, MPA
Deputy Executive Director
California Chapter, American
College of Emergency Physicians

Amanda Becker
Senior Director, Medical Economics
& Practice
American Academy of Neurology

Nicole Blankenship, MBA, CAE
Director, Division of Chapter and
District Relations
American Academy of Pediatrics

Kate Boyenga
Director, Membership and
Marketing
Medical Association of Georgia

Sharleene Cano
Manager, Membership and
Publications
American Thyroid Association

Mary Eiken, MS, RN
Executive Director
Society of Gynecologic Oncology

Michael Fraser
Executive Vice President
Pennsylvania Medical Society

Susan Motley, CAE
Executive Director
Medical Society of Virginia,
Foundation

Jim Reuter
VP, Membership & Business
Development
Wisconsin Medical Society

Anne Rzeszut
Senior Director, Market Intelligence
American College of Cardiology

Tracy Senat
Associate Director
Oklahoma County Medical
Society

Ken Slaw
Director, Membership and
Strategic Planning
American Academy of Pediatrics

Rae Young Bond
CEO/Executive Director
Chattanooga-Hamilton County
Medical Society & Foundation

Board of Directors

President
Susan G. D'Antoni
Executive Director
Montgomery County Medical
Society

President Elect
Dale Singer, MHA
Executive Director
Renal Physicians Association

Past President
Terri Marchiori
Director of Federation Relations
American Medical Association

Fraser Cobbe
Executive Director
Florida Orthopaedic Society

Harley Grant, MA
Director, Physician Services
American Medical Association

Dan Kelsey, MBA, MS, CAE
Deputy CEO
American Association of Clinical
Endocrinologists

Steve Levine
Vice President, Communications
Texas Medical Association

Cheryl Malone, CAE
Executive Director
New York County Medical Society

Allison Peterson
Director of Communications &
Membership
Kansas Medical Society

Stephen R. Phelan
Director of Membership
Massachusetts Medical Society

Jon E. Rosell
Executive Director
Medical Society of Sedgwick County

Gordon Smith, Esq.
Executive Vice President
Maine Medical Association

Contents

Acknowledgements & Introductory Remarks

Michael R. Fraser, PhD, CAE, Chair, AAMSE Trends Committee

The 2015 AAMSE Trends Report reflects some of the major issues medical societies are wrestling with across the country. The six trends described herein were identified by AAMSE members in early 2014 as part of a survey to all AAMSE members and through feedback gathered in person at the June 2014 AAMSE Conference in Louisville, Kentucky. Thanks to all our members who took their time to respond to our survey and participate in our discussions, all of which added a great deal to this report.

Thanks also to our 2015 Trends Report authors and the staff of AAMSE's management organizations — Executive Directors, Inc. (EDI) and Ewald Consulting. Staff contributed a great deal to this report: Tristan Johnson and Kim Schardin at EDI helped with editing and administrative support to get us started and Darrin Hubbard, Laurie Pumper and Joe Flannigan from Ewald helped us get it across the finish line. This report was prepared during a period of transition for AAMSE, but we were capably supported by our staff partners who did go beyond the call of duty to complete this report despite the transition (and some tardy submissions).

The oft-cited opening line from Charles Dickens' A Tale of Two Cities seems apropos to start our discussion of trends impacting medical societies: "It was the best of times, it was the worst of times…" Indeed, it is the best of times for many medical societies. New technologies allow us to connect to more physicians in new and more effective ways. Medical societies are crucial advocates for physician and patient interests in light of a very uncertain healthcare environment and the seemingly ever-changing landscape of access, affordability, and quality. It is clear that now, more than ever, medical societies are needed to stand up for the physician-patient relationship and educate and inform our members about what they need to know to be effective in the brave new world of American health care.

It is also the worst of times in many ways — it is increasingly difficult to engage members, especially volunteer leaders, who have more and more demands on less and less time, making it hard to participate in medical society activities. Physician employment is changing how many physicians view the need for organized medicine and what they expect from their employers

versus their medical societies. Our value proposition is increasingly questioned after enjoying years of member loyalty and support, and there is a wide generational divide between physicians who remember the "glory days" of physician respect, autonomy and satisfaction and a new generation that practices in large integrated delivery systems, was the first to experience residency work-hour limitations, has over $200,000 in medical school loan debt and does not need to join a medical society to get hospital privileges, meet colleagues, or network for referrals. The new technologies we depend on to share our message and show our impact also provide the platform for our competitors and generate unrealistic comparisons in our marketplace. Indeed it is hard to demonstrate value to members when they are able to easily access Google, Amazon, and other online tools developed with far more resources and technological expertise than medical societies of any type. We have a tough road to travel to remain relevant, current, and helpful to members who increasingly have other options to stay informed and learn about the practice, business, and life of medicine.

That said, medical societies continue to evolve and succeed across the United States, and many are growing to include physicians practicing in other nations around the world. We prepare this report at a time when the work of physicians is in the news daily and healthcare is front of mind for pretty much every American. The work of our members is as important as ever and the need for organized medicine to support them is as great as ever.

Best or worst times, or a little of both? You can decide. But there is no doubt these are exciting times for medical societies. I hope this report helps demonstrate how vital medical societies are to our physician members and the communities they serve.

Introduction to the 2015 AAMSE Trends Report

Michael R. Fraser, PhD, CAE
Tristan Johnson
Kim Schardin, MBA, CAE

Current and emerging trends in medicine present an array of challenges and opportunities for medical societies as they strive to maintain their viability as the organized communities physicians turn to for support and guidance. It is clear that changing technology, shifting demographics, an evolving physician workforce, and widespread reform are issues that are not going away any time soon and will continue to put strain on the U.S. healthcare system and the players within it. Medical societies can and should be at the forefront of leading physicians and patients alike through the challenges they face now and the inevitable changes coming down the road.

Physicians continue to battle rising costs of the business of medicine, face difficult decisions about how and where to practice, and struggle to achieve work-life balance while providing the highest level of care and wading through the murky swamp of reform and certification requirements.

At the same time, consumers of health care face their own struggles as they scramble to become insured, sift through an ever-increasing list of provider choices, and combat their own fears of the latest epidemics and diseases.

While these challenges as a whole may seem overwhelming and insurmountable, examined individually they reveal many opportunities for medical societies to reaffirm their role as leaders in the process of delivering and consuming health care responsibly, effectively, and efficiently. By being prepared and proactive, both independently and as a cooperative force, medical societies can make a true and measurable difference in the way physicians practice and patients receive care.

As in past years, the 2015 AAMSE Trends Report is a tool you, the medical society professional, can use to review some of the most pressing issues facing medicine and provides some basic tips for what you and your medical society can do to position yourselves as leaders on these issues. The report can serve as a conversation-starter among staff or with your board to ensure your society is discussing and preparing for current and future trends.

Once again, the Trends Report was developed and authored by the Trends Task Force, made up of AAMSE member volunteers representing a range of society types, geographic locations, and

areas of expertise. A 2014 survey of AAMSE members identified the top trends medical society professionals are thinking about. With over 100 professionals participating, the results reiterated that no matter the society type, size, or location, those working in organized medicine share the same concerns and optimism about the future. The task force used the results of this survey to shape the 2015 report.

The report includes six sections, each covering one of the top trends identified by medical society professionals. The report's sections can be used together as a single, comprehensive resource, or independently as stand-alone briefings for medical societies and their leadership.

As mentioned above, the trends covered in our 2015 report are the result of member surveys and feedback. The previous trends report (2012) looked at seven trends impacting medical societies. The current report highlights six. (See text box at right)

One trend identified as a priority in 2015 but not included in this report is "Generating Non-Dues Revenue." We expect to work with AAMSE to prepare additional information on the pros and cons of various non-dues revenue models that medical societies can develop in the future.

Trends Identified in 2012

1. **Medical Society Management** — How to demonstrate value and relevance in a fast changing healthcare landscape.
2. **Quality of Care & Patient Safety** — Understanding the role medical societies can play in working with members to improve care and advocate for patient safety.
3. **Delivery Model Changes** — Preparing physician practices for changes in healthcare and keeping physicians in the lead.
4. **Changing Roles of Non-Physician Providers** — Advocating for physician-led health care teams versus continued fragmentation and independent practice of mid-level providers.
5. **Innovation within Payment Systems** — Understanding the ways that reimbursement changes impact members and preparing them for these changes.
6. **Membership as a Value Proposition** — Working to show value to members and increase membership by offering valuable services, programs and benefits.
7. **Adjusting to the New Communications Landscape** — Adapting to new reality of communications including social media and other new technologies to communicate.

Trends for 2015 & Beyond

1. **"Coopertition"** — Blending cooperation and competition medical societies experience in carrying out their work.
2. **Responding to Changes in Maintenance of Certification (MOC)** — physician concerns about the MOC process for several large medical specialties is an area that medical societies can work on to both demonstrate value and support members.
3. **Recruiting and Serving Employed Physicians** — The increasing physician employment by large groups and hospitals or health systems has profound consequences for their connection to organized medicine.
4. **Engaging Early Career Physicians** — demonstrating value to those new to practice to engage them in multigenerational boards and leadership.
5. **ICD-10 Implementation** — Medical societies can help play a vital role in educating physician members and practice administrators on how the move to ICD-10 will change their practice.
6. **Advocacy as a Value Proposition** — Advocacy is a key aspect of our work that is often given short shrift in member outreach and communications.

The six trends described herein are:

Coopertition

A trend that describes the increasing need for medical societies to cooperate and increase competition for members among different groups. This chapter highlights the key value proposition for different types of medical societies and the key strengths and challenges they face.

Engaging Early Career Physicians

A trend that all medical societies are challenged with as we seek to involve and serve young physician members. This chapter challenges us to think about the new generation of physicians that have or will soon take on the mantle of leadership of our organizations, including the need to see them as "early career" versus "young."

Advocacy and Value Proposition

Physician advocacy is consistently rated as a key reason for members to join medical societies. This trend highlights the role advocacy can play in defining medical society value and relevance.

Recruiting and Serving Employed Physicians

The impact of physician employment on medical society membership has been looked at in a number of ways. This trend looks at how medical societies can engage "employed physicians," i.e. those physicians who work in large integrated delivery systems, large healthcare organizations or large physician practices.

Responding to Changes in Maintenance of Certification (MOC)

Physician concerns with MOC came to a head in 2014, and 2015 will be a watershed year in terms of physician satisfaction with their options for continual professional education, lifelong learning, and Board certification. This chapter highlights some of those concerns and medical society responses.

Implementing ICD-10

While delayed several times, 2015 is (most likely) the year ICD-10 will be implemented nationwide. This chapter raises some of the ways medical societies can support ICD-10 implementation and demonstrate member value.

Medical society professionals continue to serve on the front line of medicine and play a crucial role in the future of healthcare delivery in the United States. Advocating for members, engaging and serving early career physicians, preparing physicians for certification and coding changes, and cultivating a cooperative environment among medical societies are all necessary components if the organized medicine community is to succeed in its mission to address healthcare trends. A basic understanding of these trends and a roadmap to begin the quest to address them is the starting point.

Cooperation & Competition: "Coopertition" as a Key Strategy for Medical Society Sustainability

By Michael R. Fraser, PhD, CAE
Ryan P. Adame, MPA

What Is Coopertition?

Looking at the landscape of organized medicine across the country today, one sees medical societies of all different shapes and sizes: county, regional, state, national, state medical specialty, national medical specialty, and hundreds of subspecialty societies. Some are staffed by full-time employees, some are run by all-volunteer staff or members, and others are a combination of volunteer and paid staff. Still others are managed by firms specializing in medical society management. Regardless of size and staff structure, each type of medical society faces the challenge of defining their "value proposition" — that is, what value they bring to addressing physician concerns and demonstrating enough relevance and importance to compel physicians to join or retain their membership.

Developing a distinct identity and reason for being at times requires both cooperating and competing with sister medical societies of different kinds. This chapter examines the value propositions of different types of medical societies and highlights key areas where they cooperate and compete. The amalgam of these two key strategies — cooperation and competition — or "coopertition" is at the core of modern day medical society management and leadership.

It is our observation that the most successful medical societies today actively pursue opportunities to distinguish their own unique value and relevance (competition, or being the best in their "niche") while also working on shared issues and concerns (cooperation, or partnering to advance shared goals for organized medicine). We believe that it is this unique combination of cooperation and competition that medical society executives must master to be successful in today's fast-changing healthcare environment. Conversely, when one organization's leadership focuses too much on either force (cooperation or competition) they risk marginalization, lack of core purpose, obscurity, and membership decline. Why? Because today's physicians have to do exactly the same thing in their practice of medicine to be effective — skilled physicians and successful physician practices have incorporated the best elements of both forces to build their practices.

Why So Many Medical Societies?

While the way medicine is practiced and what physicians need from medical societies has changed dramatically since the incorporation

of most major medical societies, the structure of organized medicine has changed relatively little since guilds were formed to protect physician interests at various levels of governance. Most states still have some kind of local or regional network of physicians — be they county, district or other sub-state geography. In large urban areas with a concentrated physician community, it is not uncommon for medical specialties or subspecialties to also have local, urban components. Within most states, almost all recognized medical specialties also have state chapters in addition to state medical societies that cover more cross-cutting or "big tent" physician issues in their state. At the national level medical societies such as the American Medical Association, the National Medical Association, and the American Association of Physicians and Surgeons recruit physician members in addition to national medical specialty groups formed around specific areas of medicine.

The formation of different kinds of medical societies relates in part to geography, in part to politics, in part to the need for communities of like individuals to band together around their specific interests, and in part to the way physicians affiliate over the course of their training and development of their professional identities. As the diversity of the physician population expanded over time, medical societies formed around the specific racial and ethnic identity of their member physicians and differing needs for advocacy and inclusion in the overall House of Medicine. Likewise, as the science of medicine advanced and physician special-

ization increased, new societies formed around those specialties and subspecialties creating still more different groups of physicians.

In some cases, medical societies may be "unified", meaning that when you join one, you join the other. Historically, county medical societies were unified with state medical societies, and when a physician joined a county society they also joined the state society. Unification is fairly common for most national and state specialty organizations within the specialty, i.e. when you join the national specialty group you automatically join the state specialty group and vice versa. Because unified societies share members, and usually have a common dues collection and membership database/infrastructure, it may seem strange to think about competition among these entities. However, as each works to define value and relevance, they may often compete over CME offerings or other programs and publications while simultaneously cooperating on advocacy priorities or other shared goals.

The Membership Challenge

Physicians today have high expectations for their dues dollars. As medical society membership moves from historically being a professional obligation or even requirement toward a more voluntary or optional transaction, medical societies are under extreme pressure to demonstrate value and relevance and the specific ways that they make physicians' lives more productive, more efficient, and more satisfying. Gone are the days when all physicians would join local, state, and national

medical societies as well as their national and state specialties and subspecialties without asking "what's my return on investment?" Instead, medical society executives at all levels are working to sustain current value and create new programs and services to recruit additional members and retain current ones.

The membership challenge is made all the more difficult by the trend we are seeing related to physician employment. As many physicians become employed, their need for some of the services traditionally offered by medical societies, such as business of medicine consulting and practice support issues, may wane. Medical societies are seeking new ways to engage physicians and trying new membership models to recruit employed physicians, such as group or organizational memberships. Compounding the membership challenge of recruiting employed physicians, many employers cap the allocation physicians may use for CME and membership dues expenses. Anecdotally, we understand these CME and dues pools are shrinking. Hence the need for medical societies to demonstrate specific return on investment, value, and relevance creates competition for limited dues dollars as the pools shrink and dues either stay the same or increase.

The following section summarizes the various strengths and core challenges of different types of medical societies. Leadership should examine each and include ways to address challenges while building on their unique strengths and partnerships with others.

Comparative Strengths and Challenges of Different Medical Societies

County & Large Urban Medical Societies, Including National or State Specialty Society Local Chapters or Components

Key value proposition:

Most health care is locally delivered and key contacts with local and state legislators can influence statewide health policy. Local medical societies can develop community and networking because they are focused on a specific "place" and population.

Large county and metro-area specialty societies may have an advantage over county medical societies because physicians identify first with their specialty and second with their geography.

Core Strengths	Key Challenges
• Expert local knowledge, including local political influence and social capital. • Networking & referral resource in a specific place. • A local "home" for physicians in a specific place or specialty. • Extensive knowledge of local hospital and health systems. • Healthcare markets are organized locally. • Media markets are organized locally. • Unification with state or national society can make recruitment and retention easier by centralizing member data and billing. • Non-dues sponsorships and advertising often easier for a local or regional society within a specific geographic market. • Public health opportunities in a local community often easier/more tangible.	• Many physicians no longer affiliate in person, obviating need for in-person events and activities at the local level. • Referral patterns are largely dictated by insurers so networking and getting to know colleagues locally has less value today, although employed physicians report wanting more networking opportunities outside their employer or health system. • Political activity related to health policy largely concentrated in state capitals and in Washington, D.C. • Defining value vis a vis state medical societies and state medical specialties is difficult when programs and services overlap, including CME and practice support. • Unification with state or national society may make dues pricing high and complicate value proposition (i.e., who does what, where?).

State Medical Societies, Including State Specialty Organizations

Key value proposition:

As most health policy is still regulated at the state level, there is a continued need for physician engagement in state capitals. As more and more physicians become employed, they are more likely to practice in multiple institutions and organizations that are not bound by county lines, so statewide or regional groups have appeal. Core capacity of most state organizations allows for robust member benefits and programming, especially CME programs when the state is an accrediting entity.

Because physician licensure is a state function, there is also perceived value in representing physician issues statewide, especially when it comes to licensing requirements.

Core Strengths	Key Challenges
• Key players in statewide advocacy efforts and political affairs in the state capital.	• Often overlapping value proposition between cross-cutting and specialty specific state organizations. This creates competition for members who only want to join one or the other.
• Many large national specialty groups do not have on-the-ground advocates in all state capitols and as such, state groups play a major role in "situational intelligence" for national groups.	• As more and more health policy is driven by national politics, state advocacy is less relevant.
• Most insurance programs and health regulations are developed at the state level with regional implementation in cross-county markets.	• Most physicians practice locally; statewide reach not always seen as important.
• Large health systems/health plans often cover multiple counties, making group membership at the state level attractive to groups when society shows value.	• Unification can make dues pricing high and complicate value proposition (i.e., who does what, where?).
• Statewide scope provides for diverse perspectives and inclusion of rural and urban issues in policy making and society programs.	• States are extremely diverse; large geography states with low population often have limited capacity and fewer resources than high population states.
• State groups usually have capacity to offer extensive CME/ educational events such as patient safety CME and board prep courses, especially state specialty groups.	• Because county and local components have varying degrees of capacity, assuring consistency in brand when unified with these components may be difficult. This is especially true with components that are separate legal entities with their own boards of directors/trustees.
• State groups often have the scale/budget to offer robust member benefits programs in the areas of business, practice and life of medicine including practice support, legal resources, physician health and well-being and help with insurer issues.	• While many state cross-cutting and specialty societies have PACs (Political Action Committees), these are often significantly smaller than national societies and focus on state legislators/priorities versus national legislators/priorities.

National Medical Societies

Key value proposition:

As a national voice for physicians, a specialty, or subset of physicians by identity or specialty, national organizations can bring their advocacy power to bear in nationwide conversations about health policy and patient safety. The reach and large membership of national groups often allows for substantial research and publication benefits to members, such as a journal and/or magazine. National groups are significant players in setting practice guidelines and standards of care making them highly influential and relevant to practicing physicians and academic/research physicians.

Core Strengths	Key Challenges
• National reach, including connections with legislators in Washington that increasingly drive health care policy and reimbursement.	• National scope often perceived as distant from individual physicians or the concerns of a region or state.
• Large enough in scale to offer significant member benefits and programs including CME and other educational programs. National specialties are often the "go-to" organization for physicians seeking CME in their specialty area.	• Large size can depersonalize membership, making it hard to retain members who feel like "a number" or are looking to personally connect with the society.
• Unification between state and national societies allows for streamlined member recruitment and retention activities.	• Due to high profile stance on national policy issues, such as the Affordable Care Act, large groups of physicians may disagree with or feel disenfranchised by policy decisions when they are inconsistent with their personal beliefs or policies at the state or local level. While true of all societies, the national scope of these medical societies makes them an easy target.
• Historically, national societies have been large players in significant health reform initiatives and CMS policy setting.	
• Multi-state reach means more voice and "muscle" in political process, including large PAC activity in many groups.	• Significant resources are required for national groups to stay abreast of the many issues happening at the state and local level with regard to physician practice and state of medicine.
• Large size of membership and national research allows for creation and dissemination of research products and standards/guidelines for practice, including journals and research publications that inform clinical practice.	• Unification with state or national society may make dues pricing high and complicate value proposition (i.e., who does what, where?). Because states have varying degrees of capacity assuring consistency among chapters may be difficult.
• As payers consolidate and operate in multiple states, working nationally affords some efficiencies in society relationships with payers on behalf of physicians.	

References

1 "Associations Without Members." In *Civic Engagement in American Democracy,* edited by Theda Skocpol and Morris P. Fiorina, by Theda Skocpol. Washington, D.C.: Brookings Institution Press, 1999.

2 Collier, Roger. "American Medical Association Membership Woes Continue." *Canadian Medical Association Journal* 183, no. 11 (2011): E713-714. Accessed December 3, 2014.

3 Page, Leigh. "Why Physicians Won't Unite to 'Rescue' Medicine." *Medscape Multispecialty*. September 4, 2014. Accessed December 5, 2014. http://www.medscape.com/viewarticle/830152_3.

4 Collier, Roger. "American Medical Association Membership Woes Continue." *Canadian Medical Association Journal* 183, no. 11 (2011): E713-714. Accessed December 3, 2014.

5 Collier, Roger. "American Medical Association Membership Woes Continue." *Canadian Medical Association Journal* 183, no. 11 (2011): E713-714. Accessed December 3, 2014.

6 Peek, Moinca E., Shannon C. Wilson, Jada Bussey-Jones, Monica Lypson, Kristina Cordasco, Elizabeth A. Jacobs, Cedric Bright, and Arleen F. Brown. "A Study of National Physician Organizations' Efforts to Reduce Racial and Ethnic Health Disparities in the United States." *Academic Medicine* 87, no. 6 (2012): 694-700. Accessed December 3, 2014. http://journals.lww.com/academicmedicine/Fulltext/2012/06000/A_Study_of_National_Physician_Organizations_.12.aspx.

7 "American Academy of Pediatrics Joint Membership Pilot." Interview.

Trends

- Societal trends in association membership suggest that organizations with a narrower, shorter-term project focus, rather than a general, ongoing membership model, are becoming more standard.[1,2]
- Specialty societies have generally enjoyed membership growth and/or insulation from the decline in membership of larger House of Medicine societies.[3,4]
- While specialty societies may be better able respond to state-level advocacy[5], larger "House of Medicine" societies are both more capable and more likely to undertake broad public health initiatives with societal implications due to their larger membership bases and organizational infrastructure.[6]
- Some medical societies have begun experimenting with new or revised membership structures to address declining membership and/or to attempt to proactively avoid decline.[7]

Medical Societies and Their Executives Should:

1. Cooperatively analyze working relationships and programmatic offerings within their family of organizations (national specialties/state chapters, state/county medical societies, for example) in order to identify:

   a. Areas where collaboration is possible and practical: consider the pooling of intellectual and organizational resources, and utilization of economies of scale to provide member benefits more cost-effectively, and in a manner which may offer expanded professional resources for both organizations and their members;

   b. Areas where collaboration is not possible or practical: consider re-packaging and marketing those areas as distinctive but complementary facets of membership in both organizations.

2. Focus on building strategic partnerships and coalitions with other medical societies on public health issues.

3. Explore membership models that depart from the organization's historical practice, such as joint membership models, membership models that offer discounted dues for dual membership, or group memberships in individual-member associations and vice versa.

4. Consider expanding programmatic offerings for subspecialist members, such as sections, committees, or special forums that can highlight the organization's role in subspecialty education, networking, and advocacy.

Recruiting and Engaging ~~Young~~ Early Career Physicians*

Nicole G. Blankenship, MBA, CAE
Kenneth M. Slaw, PhD

"Young" physicians are a diverse, accomplished, and talented group who are experiencing a career stage in common…early career. Most reject the notion and practice that somehow they must overcome or get past their "youth" in order to be optimally effective in practice or leadership. Medical societies continue to consistently report struggles with early career physician recruitment and retention, especially in the first five years post-residency. Perhaps the struggle within medical societies to effectively deploy the talents of early career physicians is a major contributing factor. It has been demonstrated that the major differences across generations is not in their propensity to *join* associations but rather their **expectations of value** and **value delivery.**[1] Early career physicians tend toward a *different* view of what it means to join, derive value, become involved, and to be served, by their membership in medical societies. They are leading medical societies to think first and foremost about the "end user" of their products and services. They are voting with their feet if their needs can be served better elsewhere. Therefore, medical societies need to examine and consistently upgrade the value they are delivering across all member segments, strength-en alignment of value delivery to actual needs across career stages, then package and deliver the value they provide so it is easy to find, recognize, and access.[2] Early career physicians expect a seamless, user-friendly "member experience," and timely, efficient, real-time service and support.

Early career physicians have a strong expectation that their medical societies will be forward-looking, and will consistently work to earn their trust and loyalty. Trust building occurs at multiple levels simultaneously: Does the medical society work for me (individual)? Does the medical society integrate well with my health system/employer/work life (work setting)? Does the medical society contribute and do good works for society at large (society)? There is strong evidence that early career physicians will become and remain engaged in, and fiercely loyal to, medical societies that strive to adapt to their needs.[3] If opportunities to work are flexible enough to maintain the work-life balance they value highly, offer creativity and innovation, and provide an opportunity to shape the future, early career physicians will not only join, but actively co-create the future of medical societies.

Trends of Early Career Physicians

Engagement: Numerous studies show very high correlation between engagement and retention of early career physicians. Desire to engage among early career physicians is no less than any other cohort; it is the method and reason to engage that appears to be different. Early career physicians often note they are unaware of available opportunities, or that no one asked them for their input/about their needs. They are specifically seeking to link their efforts to causes and work about which they are passionate.

Debt/Financial Stress: Early career physicians are facing unprecedented debt and financial stress, approaching an average of $200,000.[4] Even with healthy starting salaries, income is not keeping up with basic loan payments for school, home, and car, that can easily add up to $4,000/month. In the first few years post-residency, there are additional substantial costs for board certification, licensures, child care, etc. With the challenge of meeting basic monthly obligations, early career physicians are relying more on employers to help with loan repayment and may be delaying purchasing membership in professional societies until they are three to five years into their careers.

The Shift to Employment: According to a recent study by the American Medical Association, nearly 42% of patient care physicians are in an employed setting, and in many specialties, it is as high as 70-80%.[5] Many employers, especially large integrated health networks, are attractive to early career physicians because they fulfill their desire for a more balanced lifestyle. Many are also providing the core benefits traditionally delivered by professional societies, potentially rendering medical societies less relevant unless they adapt. Early career physicians often lack key "survival" skills needed to thrive in a rapidly changing healthcare system such as contract negotiation and leadership skills to build and guide effective teams and lead change process.

Leadership…Now: Early career physicians are extremely accomplished, having completed and led numerous community and even international projects since high school. They express increasing desire and demand within their medical societies to engage in advocacy and leadership projects right away, and they have demonstrated they will seek opportunities elsewhere if they must. Early career physicians bristle at being treated or characterized as "future" leaders. They are leaders now, and want to be utilized.[6] Despite their experience with projects, very few have engaged in formal education in business, health care systems, or leadership skill development, as they have been fully immersed in their clinical education.

Work/Life Balance & Well-Being: Achieving meaningful work/life balance appears to be a strong core value for early career physicians as they strive to attain personal health and wellness along with meeting career goals and providing high-quality care for their patients. Early career physicians are also often starting families at the same time they are launching their career, dividing their time and attention across responsibilities. For this reason, they have shown greater propensity and need to seek part-time or flexible work arrangements.[7]

Service = Value: Early career physicians have increased demand for, and great expectations of, high-level service no matter what the content. This is a resourceful, consumer- and technologically-savvy cohort. They tend to know what they want, where they want it, how they want it, and they want the organizations they value and with whom they conduct business to make it simple and easy to complete those transactions.[8,9] Organizations that are seen as caring enough about them to meet these high expectations earn and deserve their trust. Expectations are high to transact online, and to achieve very fast access to information and services. Patience is low for websites that are poorly laid out or that require numerous "clicks" in order to find needed information. When there is a need for technical support, the expectation is that it will be accessible, and fast. If not, why be a member?

Trust: Early career physicians are seeking to build trust with their medical societies on many levels. They want to have a hand in shaping the future of their organizations, co-creating products and services, and have increased desire for their organizations to be transparent, ethical, and socially conscious.[10]

Medical Societies and Their Executives Should:

1. Invest in data strategies that will gather and provide deeper understanding of how members behave and interact with the medical society. Generational or medical specialty factors provide only a glimpse of how members filter the world or your medical society. Engagement patterns and purchase behavior is tied much more closely to career stage and professional development needs, which in turn may translate into long-term value to retain members.

2. Re-think, re-invent, and re-brand the "membership experience" for early career physicians. They want to see themselves in what the medical society does, and see tangible evidence the society understands and is striving to meet their needs.

3. Demonstrate an understanding and concern about the financial challenges early career physicians are experiencing. Explore and potentially offer programs for loan consolidation, debt management, financial planning, and insurance. Provide visible and attractive discounts. Remember, this cohort invented Groupon. They are looking for discounts.

4. Provide guidance, consultation and assistance with transition to employment i.e. contract and benefits negotiation, health care business acumen, and leadership skill building.

5. Invest in creating a service infrastructure (e-commerce, call centers, concierge/navigation services) that will meet the high expectations of early career physicians.

6. Create new and refreshed member engagement/mentorship platforms and opportunities. Invest in membership infrastructure and databases that gather interests and skill sets and match them to needs throughout the organization. Create a formal mentoring program.

7. Develop, integrate, and deliver educational programming on strategies to achieve work/life balance and time management.

8. Invite early career physicians to the table wherever there is an opportunity to have them help craft future programming and services.

References
1. Arthur C. Brooks. "Generations and the Future of Association Participation". William E. Smith Institute for Association Research, 2006. 15.
2. Harrison Coerver and Mary Byers. *Race for Relevance: 5 Radical Changes for Associations*. ASAE, 2011. 17-18.
3. Jean S. Frankel and Gabriel Eckert. *From Insight to Action: Six New Ways to Think, Lead and Achieve*. ASAE, 2012. 80-83.
4. James "Jay" Youngclaus and Julie A. Fresne. "Physician Education Debt and the Cost to Attend Medical School". AAMC, 2013. 3-4.
5. Carol K. Kane and David W. Emmons. "New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment". AMA, 2013. 10.
6. Sarah L. Sladek. *The End of Membership As We Know It: Building the Fortune-Flipping, Must-Have Association of the Next Century*. ASAE, 2011. 67-68.
7. Pediatric Life and Career Experience Study (PLACES), American Academy of Pediatrics, 2014.
8. James P. Womack and Daniel T. Jones. *Lean Solutions: How Companies and Customers Can Create Value and Wealth Together*. Simon& Shuster Free Press, 2005. 5-6.
9. Harrison Coerver and Mary Byers. *Road to Relevance: 5 Strategies for Competitive Associations*. ASAE, 2013. 2-3.
10. Weblink International. *4 Challenges Association Face in engaging young professionals*. Weblinkinternational.com, 2014.

Role of Advocacy in Medical Societies' Value Proposition

Ryan P. Adame, MPA
Amanda Becker

As health care reform has been legislated, litigated, and now implemented fully across the nation, the old political axiom: "if you're not at the table, you're on the menu" has never been more urgently true for physicians and their associations. Though the political fight continues in Washington, D.C., the exercise seems largely rhetorical given that President Obama is unlikely to agree to the sweeping changes and calls for outright repeal coming from opponents of the president's signature legislative accomplishment, the Affordable Care Act (ACA). That is not to say, however, that policy-making, reform, and implementation of the ACA is not still an ongoing process.

Physicians can increasingly access continuing medical education (CME), networking, and practice management support through many sources, including those outside of traditional professional societies. Their institutions or for-profit companies may meet those needs, possibly at a lower cost than the membership dues paid to a medical society. However, very few outside organizations advocate for physician needs beyond CME and networking, such as reimbursement or fighting intrusions into the physician-patient relationship. Demonstrating effective advocacy efforts on behalf of physician members plays a key role in the medical society's value proposition.

Perhaps more than ever, physicians and their medical societies are compelled to engage in advocacy by the conditions and opportunities in Sacramento or Austin or Tallahassee, rather than those in Washington, D.C. Because the need for robust advocacy has never been greater, it is incumbent on medical societies and their staffs to adjust their focus while developing new methods and tools to engage physicians in the process, as well as to measure and report the value of advocacy in the context of the overall value proposition of medical society membership.

Trends:

- The National Conference of State Legislatures (NCSL) identified nearly 1,200 pieces of active legislation in 2014 related to the implementation of the Affordable Care Act (ACA), with more than 2,000 pieces of ACA-related legislation having been introduced in state capitols across the 50 states since 2011[1], a figure which does not include all other health care-related legislation.
- NCSL notes that nearly half of all states are administering their own health insurance exchanges in full or in collaboration with the federal government.[2]
- The Commonwealth Fund identified some 45 states which are directly, or, in conjunction with the federal government, cooperatively enforcing insurance market reforms[3], such as bans on preexisting condition exclusions, minimum benefits, and lifetime coverage limits, while also noting that "state regulators in the vast majority of states will use their authority or collaborate with federal regulators to require or encourage compliance with the new protections."[4]
- A November 2014 Kaiser Family Foundation poll found that 68% of Americans want to change the ACA in some way — 22% favor expansion of the law, while 46% favor either scaling it back or repealing it altogether.[5]
- Physicians are among the most highly-trusted of all professions among the American public.[6]
- The lack of physician training in advocacy as a "core competency" in clinical training[7], offers

an important opportunity for medical societies to fill the void of advocacy training for physician-members.

- The nature of a physician's training and education emphasizes autonomy, problem-solving, and self-improvement. [8]
- The Alliance for Justice's "Advocacy Capacity Tool", which allows not-for-profit organizations to self-assess advocacy capacity, identified 1) detailed planning, 2) increased funding for advocacy, and 3) media relations as the three most important areas in need of improvement for not-for-profit organizations to be more effective in advocacy efforts. [9]
- Measuring the effectiveness and evaluating the return-on-investment of advocacy efforts is an emerging practice for not-for-profit organizations, [10] with far fewer practical tools available than exist for other organizational programs, such as educational conferences or membership recruitment/retention.
- Social media tools are under-utilized by not-for-profit organizations, in general, but also not utilized most effectively in terms of their ability to create a two-way dialogue between organizations and constituents. [11]

Medical Societies and Their Executives Should:

1. Re-examine the organization's advocacy program to ensure:
   a. Alignment with mission and vision;
   b. Sufficient robustness for the policy-making environment in which it operates;
   c. Staff capacity for execution, training, and oversight of advocacy program exists.
2. Increase leadership and advocacy training opportunities for members that reflect the unique mindset and work environment of physicians.
3. Focus on strategic coalition-building across provider organizations to leverage advocacy resources and effectiveness when practicable.
4. Empower grassroots advocacy by:
   a. Emphasizing and providing resources for advocacy at the state- and county-levels of government.
   b. Removing barriers to participation in advocacy by utilizing social media tools and mobile applications.
5. Re-position advocacy messaging as an integral, if not central, piece of member communications, and highlight member engagement in advocacy across communications platforms.
6. Consider dedicated funding mechanisms, including political action committees that support advocacy efforts.
7. Be transparent in communicating advocacy efforts, reporting successful and unsuccessful initiatives.
8. Develop evaluation tools and metrics in order to measure member engagement in advocacy, and the return-on-investment from all advocacy efforts, including measuring the impact of organization-sponsored initiatives as well as the averted impacts of initiatives successfully defeated by the organization.

References

1 "Healthcare Reform - Affordable Care Act Legislative Database." Healthcare Reform - Affordable Care Act Legislative Database. Accessed December 3, 2014. http://www.ncsl.org/research/health/new-health-reform-database.aspx.
2 "Medicaid and Marketplace Outreach and Enrollment." Medicaid and Marketplace Outreach and Enrollment. Accessed December 3, 2014. http://www.ncsl.org/research/health/medicaid-and-marketplace-outreach-and-enrollment.aspx.
3 "State Action on Implementation." - The Commonwealth Fund. Accessed December 3, 2014. http://www.commonwealthfund.org/publications/resources/2014/state-action-on-implementation.
4 "Implementing the Affordable Care Act: The State of the States." - The Commonwealth Fund. Accessed December 3, 2014. http://www.commonwealthfund.org/Publications/Fund-Reports/2014/Jan/Implementing-the-Affordable-Care-Act.aspx.
5 "Kaiser Health Tracking Poll: November 2014." Kaiser Health Tracking Poll: November 2014. Accessed December 3, 2014. http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2014/.
6 "Honesty/Ethics in Professions." Gallup.Com. Accessed December 3, 2014. http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx.
7 Earnest, Mark A., Shale L. Wong, and Steven G. Federico. "Perspective: Physician Advocacy: What Is It and How Do We Do It?" Academic Medicine: 63-67. Accessed December 3, 2014. http://www.ncbi.nlm.nih.gov/pubmed/20042825.
8 Stoller, James K. "Developing Physician-Leaders: A Call To Action." Journal of General Internal Medicine: 876-78. Accessed December 3, 2014. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695517/.
9 "The First 100 Users: ACT Report." Bolder Advocacy. Accessed December 3, 2014. http://bolderadvocacy.org/tools-for-effective-advocacy/evaluating-advocacy/advocacy-capacity-tool/the-first-100-users-preliminary-act-report.
10 Reisman, Jane, Anne Gienapp, and Sarah Stachowiak. "Introduction." In A Guide to Measuring Advocacy and Policy. Annie E. Casey Foundation, 2007.
11 Campbell, David A., Kristina T. Lambright, and Christopher J. Wells. "Looking for Friends, Fans, and Followers? Social Media Use in Public and Nonprofit Human Services." Public Administration Review 74, no. 5 (2014): 655-63.

Recruiting and Retaining Employed Physician Members

Michael R. Fraser, PhD, CAE
James Reuter, MBA

Why the Increase in Physician Employment?

The phrase "employed physician" is no longer unique as the shift from private practice to employment continues at a quickening pace. Recent studies have quantified what many medical society professionals have observed in their markets for years: according to data from the American Hospital Association, the number of physicians employed by hospitals grew by 34 percent between 2000 and 2010 while the number of hospital-employed primary care physicians increased from 10 percent in 2012 to 20 percent in 2014 ; and Merritt Hawkins, a large physician recruiting firm, found that in 2004 only 11 percent of physician searches were conducted by hospitals, but by 2013 that figure had risen to 63 percent.

Trends in Physician Employment

The broad economic and demographic trends driving physicians to seek employment are fairly well known and, while not the subject of this chapter, key physician survey findings are worth noting in order to understand the needs of employed physicians so that medical societies can serve them effectively:

- When asked why they chose hospital employment over private practice, 37 percent of physicians said they did not want to deal with the administrative hassles of owning a practice. Thirty-three percent said they wanted to be a doctor, not a businessperson. Overall, the lifestyle that employment offers is a significant underlying factor driving physicians to employment.

- For physicians who left private practice, the majority attributed their decision to high overhead costs. Reimbursement cuts, lack of resources to comply with ACA requirements and the administrative hassles of ownership were other significant reasons cited.

- Additional data from numerous sources can be compiled to write a separate Trends Report as to why medical practice consolidation continues; however, the purpose of this chapter is to help medical society professionals adapt to the new reality of recruiting, retaining and serving employed physicians. To be effective, this also means recruiting (and by "recruiting" the authors mean "selling your Society to") and serving the C-suite decision makers of large, integrated healthcare delivery organizations that are employing physicians. These individuals —

CEOs, COOs, CFOs and CMOs — must ultimately be convinced of your medical society's value proposition in order to justify the financial investment of membership on behalf of their physician employees, especially when membership is offered to the large group or organization and not the individual physicians.

- Medical society executives nationwide have reported that recruiting and retaining employed physician members is a top priority for their organizations. Membership decline in many medical societies nationwide has occurred in tandem with the rise in physician employment — and in our eyes, these two issues are related. This may be especially true for county and state medical societies. Employed physicians often report that the reason they no longer "need" to be members is that the core services provided by county and state societies — such as practice support with coding and reimbursement assistance — is handled by their employer. Even advocacy is not necessarily viewed as a key reason to belong by some employed physicians: large systems have their own policy and advocacy units and are perceived as advocating for physician needs along with the needs of their employers, obviating the need for individual physicians to join their county or state medical societies.
- National and state specialty societies also face the challenge of recruiting and retaining employed physician members, while their membership declines have been less dramatic than county and state societies and in

some cases specialty membership overall is on the increase. A key benefit of specialty society membership is providing advocacy for the specialty and the continuing medical education offerings specific to the specialty or subspecialty. As more physicians report that their employer provides CME and other educational offerings individual physicians may be less likely to join their national or state specialty groups. However, due to physicians' primary identity with their specialty and opportunities to recruit and retain members regardless of their employment setting, the relevance of specialty societies will most likely remain greater than county and state medical societies.

Medical Societies and Their Executives Should:

A central question for medical society professionals to ask when it comes to thinking about employed physicians is "who is our member?" Medical societies answer this question differently. Large group membership and organizational membership options have become popular in many organizations, i.e. an entire group or system's physicians join at a reduced membership rate. Indeed, in the state medical societies where membership is on the increase or holding steady, it is largely because these societies have been able to negotiate and maintain large group and organizational membership at a discounted rate based on volume. The reduced membership rate is justified by the fact that the medical society spends far less

resources on recruiting members when a large group joins and that while the entire group's physicians are considered members, not all may use the services offered at the same rate as independent physicians or physicians in private practice. A large group or organizational membership is also usually invoiced in its entirety so that individual statements do not need to be generated, saving time and administrative costs. As such, lower dues rates for group memberships are the result of potentially lower utilization of society programs and less expense involved in recruitment and retention.

As mentioned above when large groups and organizations are your members, medical society staff will have to devote a considerable amount of time justifying membership to the leaders of those groups to show value and maintain relevance to the group. This may require high-level executive meetings that you cannot make available to all members due to the sheer amount of time involved in holding them. It may also require new, large group CEO, CMO or other leader meetings or teleconferences to update members and demonstrate value to key organizational leaders, and even changing your governance to add seats to your Board or Task Forces for employed physicians and/or physician leaders of large groups.

If the employing organization pays the entire cost of member dues, rank-and-file physicians in these groups may or may not be aware of their membership as the membership is purchased "for" them.

In addition, medical societies can anticipate some pushback from independent physicians who pay their dues individually and view employed physicians as getting the same benefits for less, especially when dues reductions to recruit large groups are significant. Some organizations offer to pay a part of current membership rates to subsidize membership so that their physicians have "skin in the game." Regardless, be aware who is paying membership dues, as it will also impact the members' choice to renew — if they are given a choice. We have found that when employers pay society dues, most members renew. However, when a large group drops its membership or asks its physicians to pay some of the dues out of their own pockets, this does have significant impact on medical society membership. Anecdotally we have observed that the organizational pools from which employers pay medical society members' dues are getting smaller and physicians have had to limit the number and amount of memberships they expense to these pools. These organizational policies and fiscal realities make it even more imperative that medical societies demonstrate value and can quantify the return on investment that the organization is getting from dues dollars year in and year out.

When a medical society recruits large physician groups and hospitals/health systems as members and dues are paid by the group a significant issue to consider is this: who does your society represent when it comes to advocacy — individual physicians or the organiza-

tion that paid their dues? It is likely that as more and more physicians become employed, they may have more and more issues related to their workplace and contract terms as employees. These employed physicians may ask the society to take a position on these issues that could run counter to the interests of their employing organization. For example, while many employers (including large physician groups) benefit from restrictive covenants/covenants not to complete in their employment contracts, these often disadvantage individual physicians who may want to leave employment or move to other organizations in close proximity to their current employer. What position would your medical society take on these employment issues, and what impact would that position have on membership and the leaders of those groups who approve the group dues statements? Discussions of these dynamics should take place well before new dues categories and by-laws are written to try to minimize controversy as new groups join your society.

Core Programs

While the "who is our member" discussion is critical, another almost more important discussion is what employed physicians need and how our medical societies can meet those needs. In discussions with other medical society executives and reviews of programs and services offered to employed physicians by different medical societies, we have identified ten core programs and services that can be offered by most medical societies.

1. Advocacy

Despite the note above that some physicians believe that the advocacy work conducted by medical societies is not relevant nor necessary because they are employed, it is still the case that a majority of physicians see the need for local, state, and national advocacy groups to be their "voice" in the legislative and regulatory process. Most members, regardless of employment type, believe strongly in the organization and support the advocacy done on behalf of the physicians and patients. However, to recruit and retain employed physician members, medical societies must focus advocacy efforts on those things that matter to employed physicians in the legislative and regulatory realm. This may include more emphasis on public health issues and physician contracting rather than reimbursement or other business of medicine issues. Segmenting advocacy work to highlight what you are doing for employed physicians in large groups, as well as physicians in private practice, will help show value to prospective employed physician members. Areas to think about are legislative/regulatory issues related to fair contracting, community/public health and patient safety policies, and scope of practice issues. Developing robust policy priorities in these areas that connect to the work of employed physicians may be extremely helpful in your recruitment and retention efforts that appeal to the physician advocate.

2. Physician Leadership Development

Much has been written about the need for physicians to be both

practitioners of the healing arts but also business people and leaders within their practices and organizations. As physicians move into leadership roles in large groups and hospitals/health systems, the skill set they learned in medical school needs to be complemented by leadership competencies formerly the purview of MBAs. Many medical societies, including the American Academy of Physician Leaders, a national medical specialty group wholly devoted to physician leadership (www.physicianleaders.org), stress the need to develop physician leadership skills to succeed in new roles as managers and executives in their organizations. Medical societies can play a role in providing value to employed physicians by offering leadership development programs, potentially supplementing an organization's own program, or offering programs in tandem. Joint offerings between state groups or with hospital/health system members may be another option. Medical societies should be aware, however, that if extra fees or registration costs are associated with these programs, members may ask why they need to join the medical society for these programs when they can go elsewhere and forgo membership. Medical societies may want to consider a substantial discount or complimentary introductory leadership programs for members to show value/relevance as part of your membership. Tailoring or customizing programs for the specific needs of large institutions or organizations is another strategy to engage large groups. Offering advanced courses on year-long academies or other educational programs could then follow.

3. Quality Measures and Pay for Performance Programs

While many employed physicians report leaving private practice so that they do not have to deal with the administrative and reimbursement hassles related to medicine, they are not exempt from needing to know about how payment systems are changing and the ways in which quality metrics are evolving. An employed physician may not feel the need to join a medical society to stay on top of coding and reimbursement issues. However, they do have a profound need to understand how their productivity is being measured and how compensation is tied to quality measures within their organization. Societies that have robust practice support programs and/or consulting subsidiaries may want to investigate providing workshops and other educational events on quality metrics being implemented and pay-for-performance programs being offered by specific organizations or institutions. Societies that do not offer these services may look to partner with other local, state, or national groups that do and co-brand events and programs making them available to members again for free at the awareness building level and reduced fee for more advanced instruction.

4. Community Building, Networking and Mentoring

A core reason why medical societies formed in the first place was to provide a venue for individuals to meet, network and build community around a common interest. The need for individuals to feel a part of a community is probably as strong today as it was when our societies first formed. Clearly, however, the mechanisms and ways that those communities come together have changed a great deal. New technologies allow physician communities to be built online as in-person networking opportunities are harder to fit into members' schedules. Networking is still an important part of belonging to a medical society, although maybe not the primary driver of membership it once was. Networking and community building for employed physicians may be a particularly relevant growth area for medical society programs and services. By nature of their employment, many physicians have fewer opportunities to network and connect with physicians who are not affiliated with their organization or institution. The difficulty in meeting physicians from other organizations and institutions is an area that medical societies can address by being a bridge and connector for all physicians. Medical societies, especially local and state societies, but also national groups, can play a critical role in providing community building and networking opportunities for physicians who are independent of institutional affiliation and therefore seen as a "neutral" or "common" ground for physicians who may not otherwise meet on a routine basis. In addition to ad-hoc networking programs, mentoring programs that match physicians new to practice or new to the area with more seasoned physicians are another way to create connections between employed physicians and medical societies.

5. Communicating Need-to-Know Information to Employed Physicians

A core function of medical societies is to help members stay current on issues in the profession of medicine, be it from a specialty specific or geographic perspective. Regardless of employment setting, physicians need to know how new regulations, legislation and trends will impact their practice. Medical societies have a history of sharing need-to-know information with physicians — through print publications, emails, webinars, teleconferences and in-person events. All physicians, regardless of employment status, should see value in being kept up to date with need-to-know information that is important to them and their patients. Medical societies are a trusted source of information in the very uncertain and changing healthcare environment.

Communications to employed physicians should feature issues or items that are not to be duplicated by their institutions or systems lest the medical society communications be seen as redundant. For example, one state society has worked with large groups and institutions in their state to co-brand a newsletter that provides helpful information to physicians but also items of import to their employing organizations. This creative initiative helps bring value to members and to the employer — saving time and avoiding redundancy. Another initiative being developed by a state medical society is to identify a hospital or large group liaison to the medical society and provide current information on society activities to that member so that they become a conduit for information and can share what the society is doing for employed physicians and the entire medical staff.

One technical issue to be mindful of when communicating with employed physicians has to do with the logistics of communication. Many institutions no longer have mailboxes or even physician lounges where information can be posted or shared, and instead rely on email communication. It is often the case that communications from organizational entities like medical societies can be treated as spam by institutional firewalls. Therefore, medical society professionals should inquire if members wish to receive member communications at a home address or personal email versus the organizational addresses that may block messages no matter how important or useful to physician members. Having a contact within the large group or organization's IT department is another way to get your medical society "whitelisted" for member communications and assure your messages are being delivered to members.

6. Continuing Medical Education & Accreditation

A core benefit of many medical societies is the ability to earn free or reduced price continuing medical education as part of membership. While the format of these CME events is changing, i.e. more online than in-person events, we are also seeing growing competition by CME providers, including medical societies. Many large groups and hospitals/health systems provide CME opportunities for their employees. As this trend grows, medical societies face stiff competition to demonstrate the value of their CME over others. One strategy to adapt to these changes is to work with specific groups and/or systems to co-brand or collaboratively design CME programs. By being seen as a valuable partner in the development of CME, you may be able to grow membership even in facilities that provide CME for their physicians.

If your medical society is also a CME accreditation provider, you may be able to offer services to large group and organizations that need an accrediting body for their programs. Another strategy is to provide specialty specific or geographically specific expertise that would be hard for others to provide as expertly or as well. For example, CME on new state regulations and how they are being implemented is a good source of content for a medical society CME program that could apply to all physicians and most likely not something to be offered by an organization or individual employer. The issue here is to identify those topics and issues that employers will not or cannot offer because your medical society is seen as the expert and then deliver excellent programs that show value in membership.

7. Professional Benchmarking Services

An area for continued growth in all medical societies is the ability to provide relevant "business intelligence" to our members, including benchmarking reports on compensation, quality and other data relevant to members and their

employers. Collecting new data or repackaging secondary sources of data on physician compensation and performance may be of value to members seeking an independent, trusted source of information to compare against what they receive from their employer. Several medical societies provide data to members on productivity, quality, and outcomes of various procedures that members use to benchmark their own performance. As these data are not often easily available to physicians, or as employed physicians want a source of information that is outside their own system, medical societies can fill a void in this area. Key to this service is providing data not easily or affordably available elsewhere as a member benefit and distributing it in a way that is accessible to physician members. Again, charging additional fees to get these data add little value to membership and might be seen as "nickel and diming" members for something they could go directly to the source to obtain.

8. Contract Review & Other Legal Services

As more and more physicians become employed, more and more will need access to legal services to review their contracts and assure they are fairly compensated in their employment agreements. While contract review is hopefully not an annual need, medical societies that provide some kind of periodic legal review services will be seen as valuable to physicians who are in need of such services and either do not have their own legal counsel or do not have the time to identify one. In addition to

contract review, medical societies can also use the benchmarking data discussed above to determine if a contract includes reasonable RVU/productivity goals and other market-based standards. Several medical societies provide this legal review service in house, or through referral to pre-screened attorneys with a specialty in physician employment agreements. One item to consider is that if contract review services are provided at a reduced fee versus free of charge, that fee may be seen as an "extra charge" for something they believe they should "get" with membership. Explaining what is and is not included as part of the contract review service is extremely important. Some state societies provide a general "things to consider in your employment agreement" checklist or educational program and discounted legal review as an additional service. This is also an area that might be segmented and promoted to early career physicians who are negotiating their contracts for the first time and to physicians who are looking at contract renewals.

9. Clinical Remediation and Competency Assessment

Many medical societies are positioned to be the champions of quality patient care, helping members stay current with state-of-the-art science and treatment guidelines. When a physician faces challenges to practice due to aging, addiction, anger management or stress, medical societies are uniquely positioned to provide peer-to-peer assistance and support. Employed physicians may not wish to utilize in-house Employ-

ee Assistance Programs for fear of confidentiality issues or that by admitting they have challenges or competency issues they may jeopardize their employment. Medical societies that offer Physicians' Health Programs or other services to support impaired physicians will play a key role for employers looking to support their employed physicians. In addition, programs that help assess physician competency can help improve quality, keep physicians practicing longer and more productively. Medical societies that do not offer these programs may wish to develop partnerships with medical societies that do, especially when their members may overlap — such as state medical societies and state specialty societies.

10. Addressing Physician Well-Being & the Life of Medicine

A growing area of program development for many medical societies is a new focus on physician satisfaction and well-being. Managing stress, avoiding burnout, balancing medical practice with personal goals and relationships, financial planning, and how to succeed in different kinds of practice environments are all ripe areas for medical society programming regardless of specialty or geography. Employed physicians may have different interests in these topics than independent physicians, but still may see benefit in what we term "life of medicine" educational opportunities. Medical societies may want to offer wellness assessment, retreats, workshops or other events either online or in-person in conjunction with

large groups and hospitals/health systems. Such jointly sponsored programs demonstrate both the value of the medical society but also the commitment the employer has to the health and wellbeing of its physician employees.

Medical society professionals and many physician leaders often wax nostalgic for the days when society membership was essentially required for physicians to practice in their communities and we enjoyed impressive membership penetration rates and prestige. As membership in medical societies has become less of a professional obligation and members increasingly ask their medical societies to demonstrate value and relevance, the value proposition for physicians to join has taken on a very transactional nature — i.e., we provide these services to you/for you/with you for your dues dollar. We cannot let the transactional nature of "marketing" membership detract from the core reason we exist: to advance our mission. If your organization's mission is robust and broad enough to include all physicians, any physician should want to support you as a cause. The issue is that many of our missions need to be reworked in light of the changing needs of physician members and the transformations in health care delivery and economics. As such, the value proposition for many county and state medical societies has been based in a large part on physicians owning small practices and relying upon the medical society for advocacy and practice support services to help them thrive as both medical professionals and

businesspeople. The trend to employment and consolidation has changed what physicians expect from their medical societies and who medical societies represent — and medical societies are challenged to respond.

There is danger, however, in overplaying the differences between employed and independent physicians. All physicians, regardless of employment setting, need an advocate for their profession and specialty and a resource for the business, practice and life of medicine. The key to recruiting and retaining physician members is to segment the issues and activities that are most relevant to the two different groups and use these segments to drive member communications. The activity areas suggested above are meant to guide medical society professionals toward creating member value, meeting member pain points and forecasting those issues our members will need to address to be effective physicians well in the future. This will require openness to change, a culture that supports innovation, and members who are willing to support new approaches to their work.

References

1   http://www.theatlantic.com/
    health/archive/2014/05/should-doc-
    tors-work-for-hospitals/371638/?sin-
    gle_page=true
2   http://www.jacksonhealthcare.
    com/media-room/articles/
    physician-trends/physician-da-
    ta-on-practice-environment-work-
    load-and-patient-access.aspx-
    ?utm_campaign=Physician%20
    Practice%20Environments%20
    7.11.14&utm_medium=email&utm_
    source=Eloqua
3   http://www.theatlantic.com/
    health/archive/2014/05/should-doc-
    tors-work-for-hospitals/371638/?sin-
    gle_page=true
4   http://www.jacksonhealthcare.
    com/media-room/articles/
    physician-trends/physician-da-
    ta-on-practice-environment-work-
    load-and-patient-

Responding to Changes in Maintenance of Certification (MOC)

Susan Motley, CAE
Anne Rzeszut, MA

For more than half a century, traditional continuing medical education (CME) has been a U.S. physician requirement for the advancement of knowledge in the medical profession. Yet within the past decade, there has been a push toward new innovative educational formats, which support improved patient outcomes.

Maintenance of Certification (MOC) programs aim to promote lifelong learning and the enhancement of the clinical judgment and skills essential for high quality patient care. Introduced in 1999 as a part of an evolution in recertification to support continuous professional development, MOC is a four-part process that requires ongoing measurement of six core competencies — professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice.

On January 1, 2014, the American Board of Internal Medicine (ABIM) implemented changes to its MOC program for board-certified internists to mirror American Board of Medical Specialties (ABMS) and American Board of Family Medicine (ABFM) requirements that apply to all certified physicians, including those originally grandfathered. Meeting MOC requirements is defined as passing a secure examination after training and maintaining a 10-year certification contingent upon completing MOC activities as follows:

- Some MOC Part II Medical Knowledge or Part IV Practice Assessment activities are required every 2 years;
- 100 MOC points are required every 5 years (20 points minimum in both Part II and Part IV). The remaining 60 points may be earned from either Part II or Part IV activities;
- Completing patient safety and patient voice modules required every 5 years;
- Secured reexamination required every 10 years (Part III – 20 MOC points are awarded for taking the exam, regardless of a pass or fail decision).

The following trends are emerging in response to the changing MOC requirements.

Trends

MOC Enrollment

Physicians are enrolling in MOC. According to ABIM, in accordance with the May 1 deadline, almost 150,000 physicians signed up for MOC out of a possible 200,000 to 220,000 who hold either a lifetime or time-limited certification; 77% of time-limited physicians enrolled by the deadline with the participation rate passing 80% for cardiologists, endocrinologists, gastroenterologists and oncologists. In contrast, only 21% of grandfathered physicians had enrolled as of June 2014.

Efforts to Reverse or Restructure MOC

Almost 20,000 physicians have signed a petition stating that "MOC activities are complex, have questionable value, and detract from more worthwhile pursuits including patient care and other educational activities," calling for a return to recertification every 10 years and removing the new MOC requirements.

In April, the Association of American Physicians and Surgeons (AAPS) filed a lawsuit in federal court against ABMS stating it restrains trade and reduces patients' access to their physicians.

The American Medical Association and state medical societies in New Jersey, Michigan, Ohio, Oklahoma, New York and North Carolina have enacted resolutions against MOC.

A survey conducted in May with over 4,400 cardiologists found strong opposition to the changes; opposition is universal, cutting across generations. Much of this opposition was driven by the high financial and time costs associated with the new requirements and lack of perceived value. One-third reported changing future plans — retire early, transition out of practice, work part-time — in response to the new MOC requirements. Not surprisingly, there was a strong call to remove the MOC requirements.

Redesigning MOC Elements

In response to physician concerns over the 10-year secure exam and requirements for Part IV (Practice Assessment), ABIM is redesigning some of the MOC elements, relaxing several financial and coursework requirements. Detailed responses provided by ABIM include:

- ABIM will streamline the process for recognizing products produced by specialty societies and other organizations for Part II Medical Knowledge points.
- ABIM will explore pricing options whereby diplomats, over their 10-year exam cycle, can opt in/out of access to ABIM products and, if they opt out, get a discount on their MOC fee. Any diplomat who takes an exam before his/her examination is due and fails, will get an additional year to pass before being reported as "Not Certified" or "Not Meeting MOC Requirements." In addition, first-time MOC retake fees will be reduced from $775 to $400 starting in 2015. The ABIM Board of Directors will discuss website language for "meeting MOC requirements" at its upcoming August meeting. The Council will charge each specialty board with addressing the question of whether underlying certifications are required in each tertiary specialty and conjoint boards; decisions are expected by 2015 for the Boards which ABIM administers. These considerations will pertain to our members who now must pass the general cardiology exam before sitting for their interventional, electrophysiology, or heart failure exam.
- A newly formed committee, established at the June ABIM Board of Directors meeting, will examine expanding MOC options for clinically inactive (and less clinically active) physicians, including researchers, academics and administrators.
- A formal strategy for society/specialty board communication will be developed, in consultation with the specialty societies, with discussions beginning this fall.
- ABIM welcomes the opportunity to partner with other professional organizations on research to assess the efficacy of MOC.
- ABIM will work with professional societies to further understand the burden imposed by MOC.
- ABIM has begun the process of revising the criteria for the patient survey (patient voice) module. It is anticipated that there will be four different pathways to meet these requirements by 2018.

Clearly there is a great opportunity to support physicians in this changing landscape.

Medical Societies and Their Executives Should:

1. Stay informed on the latest MOC requirements and assume a leadership role in educating physicians.
2. Serve as the reliable, up-to-date, clear source for developments in certification.
3. Set expectations about the time and resources needed to fulfill requirements.
4. Ensure their physician members stay abreast of their MOC obligations.
5. Create/enhance a centralized learning portfolio to earn, manage and track credits and anticipate exam requirements.
6. Be a strategic partner. There is an opportunity to work with boards to improve the MOC process. Stay abreast of member successes and hurdles in fulfilling requirements and share these insights with relevant boards.
7. Expand offerings for earning Part II points; focus on increasing the amount of online Part II activities.
8. Explore opportunities to provide relevant Part IV points.

References
1. Lowes, Robert, "MOC Shock: ABIM Program Signs Up Most Docs", *Medscape Medical News,* June 4, 2014.
2. Hertz, Beth Thomas, "MOC Changes Aim to Lesson Burden on Physicians, But Debate Continues", *Medical Economics,* March 24, 2014.
3. "AAPS Takes MOC to Court", October 24, 2014.
4. "ABIM Letter Outlines Commitment to Internal Medicine Community Regarding MOC", *ACC in Touch Blog,* July 21, 2014.

Implementing ICD-10

Susan Motley, CAE

Currently, ICD-10 is scheduled for implementation in the United States on October 1, 2015. It will replace ICD-9, the current code sets used to report medical diagnoses and inpatient procedures. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA).

Trends

The Centers for Medicare and Medicaid Services (CMS) has delayed the transition to ICD-10 several times due to Congressional action at the request of the provider community, and in particular, the American Medical Association (AMA). ICD-10 will significantly expand the number of medical billing codes from approximately 13,000 under ICD-9 to more than 68,000 diagnosis codes under ICD-10. Resistance to implementation has been driven by the cost to upgrade billing systems, electronic medical records systems, and time to allow for system testing.

Preparation

Not being prepared for this transition has financial implications. Improper diagnostic codes in claims will result in decreased reimbursements, delays, and denials. Many providers have already invested capital preparing for the transition and this has not been limited to new software and ICD-10 coding books. Medical practices have been advised to allocate resources — time and money — in four key areas:

• Coding
• Revenue cycle
• Project management
• IT

Many medical societies have sponsored workshops and brought in trainers in an effort to prepare their members for ICD-10. While this was an incremental financial gain for some organizations, others did not see revenue because of having to refund fees when the implementation was delayed. CMS offers a resource, Road to 10, to help small physician practices prepare for the Oct. 1, 2015 compliance date. This includes a Road to 10 website, with special resources for various specialties to help build an action plan to prepare for the upcoming deadline.

Taking Action

Currently, the AMA as well as many state and other national medical organizations from across the country are joining together to ask for a two-year delay in ICD-10 implementation. There has been a call to action during the "lame duck"

session of Congress that pairs this issue with SGR (Sustainable Growth Rate) reform and positions both as critical issues due to monetary costs — especially to physicians.

The American Health Information Management Association (AHIMA) has been on the other side of the issue advocating for implementation. Last year, after the delay was announced, it released the following statement: "Although the delay was disappointing, the benefits of ICD-10 are too important for us to become discouraged," said AHIMA CEO Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA. "The greater specificity of ICD-10 will not only benefit population and public health and research, but will maximize the return on investment in initiatives such as electronic health records, meaningful use and performance measures. This will ultimately lead to what everyone wants — improved patient care and reduced costs." AHIMA has launched an ICD-10 advocacy, outreach and education campaign to ensure

its stakeholders are well informed regarding the importance of the ICD-10 transition and the impact of any further delay.

ICD-10 transition had a moment in the news during the recent ebola outbreak when the World Health Organization mentioned that the outbreak could not be easily or adequately tracked globally because the United States has not implemented the change.

Medical Societies and Their Executives Should:

1. Provide resources to their members for the implementation of ICD-10, including webinars, in-person programs, literature, online discussions, help-line or practice support materials for physician practice questions and concerns.
2. Decide if they are going to lobby for a delay by surveying members and share those results with policymakers.
3. Stay abreast of the issue, including the push by some to skip ICD-10 and go for ICD-11.

References
1. www.icd10watch.com
2. www.ahima.org

2015 TRENDS REPORT

AAMSE