Exective Director

BY JAMES G. (Jim) BECKNER

"This is day one"

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First, I want to thank the membership and the Board of Trustees for this honor. It’s a great responsibility to lead such a historic and at the same time progressive organization. I have learned a great deal from watching Peter carry this responsibility with such grace. I will look to him over the next two years for advice.

I also look forward to working with our new Executive Director, Jim Beckner, who has hit the ground running over the past year. And I want to thank Deb Love, who encouraged me to get involved with RAM several years ago. She has become a good friend over the years, and we should thank her for her enormous contributions to this organization.

Second, I need to recognize the mentors and role models whose examples I have tried to follow: My father, who was an oral surgeon in Richmond; Dave Hume, who inspired me to pursue surgery; Richard Wilson at the Brigham who stimulated my interest in surgical oncology; Bernie Fisher of Pittsburgh and the National Surgical Adjuvant Breast and Bowel Project, who showed me how gratifying clinical research could be; and Walter Lawrence, who escorted me up here this evening and who has taught me so much — especially how to hit a sneaky lob and who also encouraged me to be active in RAM.

Third, I must thank my family, especially my wife of 35 years, Christine, and my three boys, Phillip and Michael, who are here, and Brian, who’s in Thailand. I am grateful for their support and forbearance all these years and for putting up with my not being there as much as I would like.

Tonight, I will discuss a subject that you probably have heard about more than you like already, but one that must be faced and that I think can be improved upon if we all do our part as doctors and as advocates — the massive cost of health care in the United States.

The scope of the problem is not new to anyone, but a few facts will help set the stage. U.S. health care costs have now exceeded 3 trillion dollars annually, or 18 percent of GDP. At almost $9,500 a year per person, “Day,” continued on page 2

Board certification: Why it matters to doctors and patients

By ISAAC L. WORNOM III, MD, FACS

Board certification was something I personally strived for throughout medical school and surgical training. It was the thing that told the world I had succeeded in becoming a specialist in plastic surgery, and I know taking that final oral exam and passing it was one of the most stressful and hardest things I have ever done.

The preparation for the test was intense … compiling a list of every patient I had treated for one year and sending that list to the American Board of Plastic Surgery, getting a list of 10 random patients from the board whom I then had to prepare books on, including their medical records, pre- and post-op pictures and even the chart that was sent. Then I had to go before the board to discuss my patients’ care in an oral exam where any question was fair game. I will never forget weeks later right before Christmas when I opened that envelope out by my home mailbox and found out I had passed. What a present that was.

The American Board of Plastic Surgery is one of 24 medical specialty boards that make up the American Board of Medical Specialties (ABMS). According to the ABMS website, these boards “work together to establish common standards for physicians to achieve and maintain board certification.” The Boards were founded by their respective specialties to protect the public by assessing and approving doctors who meet the highest standards of training and competence.

"Certification,” continued on page 3

No quick fix for opioid abuse

"I can’t take it any MOC!”

Game of (healthcare) thrones
this is roughly double the annual per capita costs in all of the other industri- alized countries in the world. Health care is the largest business in our na- tion; if it were a country, it would be the 5th largest economy in the world. And what do we get for all of this spending? Our ranking in health care outcomes is 36th in the world, infant mortality is 30th and our life expec- tancy ranks 50th. The U.S. ranks 46th out of 48 industrialized countries in overall health care efficiency. How do we get so little for so much? It all relates to how we spend our health care dollars. Seventy five per- cent of the expenditures are on people with chronic illnesses, many of which are potentially preventable, fueled by tobacco use and obesity. Currently, three fourths of Americans are over- weight or obese. Half of all our health care spending is for 5 percent of our population. And, perhaps most dis- couraging, 31 percent of the dollars spent in the health care business are wasted on administrative costs. At the risk of being impeached on my first night in office, I will tell you that 31 percent is twice what is spent on administrative costs in single payer systems, like Canada, Medicare and the single payer systems that provide care for millions of Americans who work for large corporations which don’t employ insurance company intermediaries. It has been estimated that a single payer system would save us $380 billion per year. We could care for a lot of uninsured people for that kind of money! Furthermore, physicians are also forced to waste money because of the complexity of our system; nearly 14 percent of practice expenses are on billing, which is quadruple the cost in Canada. You and I both know that a single payer system for the whole country is not politically viable, but the prob- lems created by massive spending and waste are, to some extent, the inevi- table result of politics, special interest influences and the fact that health care has become primarily a business in a capitalist system. And it is a disorga- nized hodgepodge to boot. Pfizer and Johnson & Johnson are among the top 20 U.S. firms in profits. Merck, J&J and Proctor & Gamble have had the biggest increases in spending on lobbying of any companies in the U.S. But administrative waste and cor- porate greed are not the whole story. A lot of what author and surgeon Dr. Atul Gawande has termed “over- kill” is related to things we can do something about, including how we practice and other things that we can influence indirectly, including:

- Avoid unnecessary X-rays, tests and procedures that physicians order on patients every day. I know it’s not me, and I doubt that it’s you, but somebody is doing it. A recent study from Dartmouth examined the value of tests for a large population of patients with newly-diagnosed breast cancer, including CXR, CBC, LFT’s and found they had absolutely no value. Quite a few abnormal results led to other tests, includ- ing CT scans, PET scans, etc. and no occult metastatic disease was found as a result. And just this month the results of a survey of surgeons was published indicating that nearly 40 percent of surgeons performed unnecessary metastatic workups for early-stage breast cancer, and many performed inap- propriate tests, even when staging workup was indicated.

This could result either from physicians being misinformed or from patients insisting that they have these tests. But I think the latter is doubt- ful. In fact, data published in JAMA Oncology in 2014 indicated that of all the tests ordered for cancer pa- tients, only 8.7 percent resulted from patient demand, and, of those, only 11 percent were inappropriate. In my experience, patients actually do get it when you explain to them why a test is not going to be helpful and may actually lead to more harm than good, and it usually takes only a minute or two to get it across.

- Stop practicing “defensive medi- cine,” which has been estimated to cost $210 billion a year in the U.S. Become better stewards of our resources. Dr. Atul Gawande, who I am privileged to call a friend, has cited many examples of “over- kill,” including the overdiagnosis and overtreatment of tiny thyroid cancers and other indolent cancers that would never have caused sig- nificant harm. In my own field, this argument has caught fire for duct carcinoma in situ of the breast, even leading to a Time cover story asking “What if I decide to just do nothing?” Gawande notes that every year in the U.S., we order 1.5 million nuclear medicine scans, 100 million CT and MRI scans and 10 billion lab tests. We have all seen the unintended conse-quences of some of these tests, often leading to additional tests to clarify the results of the first unnecessary test, a phenomenon I refer to as a “red herring parade.” Now I know that we and the MSV are pushing to do away with prior authorization requirements, or what I like to call “Mother may I” barriers for imaging tests, but, as a profession, we have not been good stewards of our resources, and it is hard to be too critical of those try- ing to slow down the use of testing that’s not beneficial. It’s just that it comes across to us most of the time as arbitrary, inconvenient and obstructionist. While I certainly agree that we need to change this process drastically, we do bear some responsibility to focus more on cost-conscious care and value. If we do not, we will be forced to do as we are told, by private and public payers.

- Advocate for more sensible drug pricing, and choose drugs for your patients based on value.

We know that one of the biggest contributors to U.S. health care spending is the escalating price of drugs. The average cost of cancer drugs was $10,000 per month in 2013, and with new drugs coming out almost every
week, it will continue to rise. Two new cancer drugs go for $35,000 a month. The estimated cost to develop a new drug today is one billion dollars, and pharmaceutical companies, in search of maximal quarterly earnings, want to recoup that cost as quickly as possible. The profits are enormous, and the main reason for continued price escalation is politics rather than research. Probably the two main drivers of high prices are that drug companies will charge what the market will bear and, secondly, that Medicare is expressly forbidden from negotiating drug prices with Pharma, a condition that was preserved in the Affordable Care Act. The VA, on the other hand, is able to negotiate drug prices, resulting in CMS paying prices that are 80% higher compared to what the VA pays. For drugs developed, manufactured and sold in the US, 13 percent of revenues goes to R&D, 31 percent goes for marketing, and 20 percent is profit.

- We need to end what Autilio Gawande calls the “medicalization of mortality,” with patients near the end of life getting treatments and procedures that do more to increase suffering and pain rather than improving well-being. Consistently over the past few decades, one quarter of Medicare expenditures occur in the last 12 months of life. We have not done well at allowing patients and their families to choose how aggressive their care would be as they approach the end of life.

As I embark on this term as your president, I would like to emulate Jeff Bezos, the founder and CEO of Amazon, one of my favorite companies. When he was asked about how far his company had come and where it was headed in the future, he responded that “This is Day One,” meaning that every day is an opportunity to improve and grow. For RAM and medical care in the Richmond area, I hope that we all will act like “this is day one.”

Board certification does play a very important role in reassuring the public that the doctors they are seeing are well-trained and practice at a high level.

**“Affordable Care Act. The VA, on the”**

**“Certification,” continued from page 1** certifying doctors who meet specific educational, training and professional requirements.

- Hospitals use board certification as one of the primary ways of credentialing their medical staff. In Richmond, it’s very hard to practice in a hospital environment without it. It is quite possible, however, to practice medicine and surgery without board certification in an outpatient office setting because the Common-wealth of Virginia will grant a license to practice medicine and surgery to individuals who have received their MD degrees, have done one year of postgraduate training (i.e. an intern-ship) and have passed the National Board or some similar exam. This is a much less rigorous requirement than completing a specialty residency and passing board exams.

- Despite the importance that hospitals and medical staffs place on board certification, I am not certain that patients are always aware of what it means. This is especially true in my own field of plastic surgery. Plastic surgery encompasses both reconstructive and cosmetic surgery, and the cosmetic surgery realm can be particularly confusing to a patient trying to figure out board certification and what it means. In addition, most cosmetic surgery is done in outpatient office settings so hospital credentials to perform it often do not matter.

- In addition, there are multiple boards that certify cosmetic surgeons. Some of the boards are members of the ABMS and some are not. Both the American Board of Plastic Surgery (a member) and the American Board of Otolaryngology (a member) claim cosmetic surgery of the head and neck as part their purview as does the American Board of Oral and Maxillofacial Surgery, and the American Board of Plastic Surgery — and not the Board of Medicine — is charged with the regulation of cosmetic surgery performed by oral surgeons in the commonwealth.

- Result? Our own Richmond Times-Dispatch poll of its readers about the best of Richmond listed an oral surgeon among those folks readers could vote for as the best plastic surgeon — and he won. He is not certified by the American Board of Plastic Surgery but rather is certified by the American Board of Oral and Maxillofacial Surgery.

- What a morass of boards! Indeed, I felt confused myself just trying to write the previous paragraph in an effort to explain all this to you. So can you imagine how a prospective patient looking for a board certified surgeon might feel?

- There is currently quite a contro-versy brewing in the world of internal medicine about the issue of mainte-nance of certification or MOC. MOC is a process by which doctors are evaluated periodically, typically every 10 years, on several standards to be sure they’re still practicing medicine at a high level. Up until the 1990s, most certificates issued by certifying medical boards were not dated and did not expire. At that time, the certifying boards started dating their certificates to expire in 10 years and required their diplomates to re-certify if they wished to maintain their certification. Usually some type of computerized test is required, and all this costs doctors time and money.

In the world of internal medicine
As we begin 2016, the Academy has much to be thankful for. And topping that list is you, our amazingly talented members! Although we can't give all 2,500 of you a ring, we pledge to be your partner in our “engagement” and keep you informed and connected as we collectively embark on another year together.

Through conversations and focus groups with members, we’ve heard from you and will continue to work to align your personal and professional needs with the programs and services that RAM offers.

Communication: As in every good relationship, communication is key! We want to make sure you’re getting need-to-know information without flooding your inbox. As members, you should be receiving two weekly e-newsletters: The Leg.Up comes to you every Wednesday evening with local and national news of interest to the physician community. RAMRounds comes every Friday evening with information about RAM and community events as well as member announcements. Details about upcoming RAM programs are also found on our calendar of events at www.ramdocs.org. Look for new, more mobile-responsive event notices with increased user-friendly registration coming your way this year. Would you prefer to opt-in to receive text alerts on your mobile device to RSVP for events? Is there another method through which you would prefer to hear from us? Let us know!

Connecting the Silos: While the practice of medicine has become increasingly interdisciplinary, the face-to-face physician communication and interaction has not kept pace. While we can’t increase the number of hours in a day (although oftentimes we’d like to) we can provide more “bang for your extracurricular buck.” The Academy will look to marry your existing needs with the “value add” of networking and getting to know your colleagues. Everyone needs a pumpkin in the Fall, right? Why not join your colleagues and bring your family to our new Fall Family social to get in the autumn spirit while meeting and getting to better know your fellow physicians. Have a volunteer idea or activity you’d like to pursue? Let us help you convene other physicians to join you. And don’t forget about our online member database. As a membership organization, we see value in sharing your professional information with colleagues. Log in to make sure your practice information is up to date and choose any additional information you’d like to make public to fellow members.

Share the love. Do you have a colleague who would enjoy joining you at a member dinner or social? Or an old friend from med school in town you haven’t seen lately? Invite them to the next member program with you. What’s stopping you from bringing a guest? To encourage bringing others out, we are sweetening the deal and adding a new healthy competition to the mix. (See sidebar on page 5 about “RAMgagement”). We’ll periodically publish a leader board so you know where you stand. So be sure to talk up our events in your office and bring your buddies along with you! We also want to make sure members feel welcome at member programs. Look for Academy leaders serving as new “RAMbassadors” at our events to greet new members and introduce them to others.

We are excited for the year ahead and look forward to working together in 2016!

Membership feedback and new ideas are always welcomed! Please contact Kate Gabriel (804) 622-8133 or kgabriel@ramdocs.org.

“As a subspecialist I very much enjoy the general medical interest and policy-related speakers from the meetings — it remains one of the best ways in my life to stay abreast of news and changes in healthcare.”

~Steven C. Smith, MD, PhD
Department of Pathology, VCU Health System

“As a fairly new member of the Richmond medical community, I appreciate the opportunity RAM affords me to interface with a variety of practitioners in the area. My ability to care for patients is enhanced by my professional relationships with other members of the community-wide care-giving team.”

~Meredith L. Diehl, MD, Commonwealth Eye Care Associates

"We winter 2016"
Should you have questions about any of our upcoming meetings, please call the Academy at (804) 643-6631. Do you have a colleague interested in becoming a RAM member? Bring them along to the next RAM event!

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<tr>
<th>DATE</th>
<th>MEETING/LOCATION/TIME</th>
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<tbody>
<tr>
<td>March 1, 2016</td>
<td>Lunch on Tuesday</td>
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<td>Tuesday</td>
<td>Speaker: Marsha D. Rappley, MD, CEO, VCU Health System &amp; VP, VCU Health Sciences Westwood Club 6200 West Club Lane, Richmond, VA 23226 12:30 – 1:30 p.m.</td>
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<td>March 22, 2016</td>
<td>RAM Member Social</td>
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<td>Garden Grove Brewing Co. 3445 West Cary Street, Richmond, Virginia 23221 5:30 – 7:30 p.m.</td>
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<td>April 12, 2016</td>
<td>Lunch on Tuesday</td>
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<td>Tuesday</td>
<td>Speaker: David Elliott, MD Doctors Without Borders Westwood Club 6200 West Club Lane, Richmond, VA 23226 12:30 – 1:30 p.m.</td>
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<tr>
<td>May 10, 2016</td>
<td>RAM Membership Meeting</td>
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<td>Tuesday</td>
<td>Speaker: Richard P. Shannon, MD Executive Vice President of Health Affairs, University of Virginia Country Club of Virginia 6031 St. Andrews Lane, Richmond, Virginia 23226 5:30 p.m. cocktails, 6:15 p.m. dinner, 7 p.m. presentation</td>
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Some of RAM’s illustrious former presidents were all smiles as the audience rose to applaud them!

Dr. John McCurley of Bon Secours’ St. Francis Medical Center.

Drs. Nan O’Connnell and Deborah Barron join HCA hospital executive Terika Richardson at the January RAM gathering!

Former RAM President C.M. Kinloch Nelson, new Student Trustee Michael Armstrong, student member Elizabeth King, and Dr. Walter Lawrence enjoy the presidential inaugural event in January.

Some of RAM’s illustrious former presidents were all smiles as the audience rose to applaud them!
Opioid abuse: No quick fix

BY LISA CRUTCHFIELD

The new patient is polite, well-dressed and articulate. He’s visiting a friend in the area but forgot to bring his medication. Could you help by writing him a prescription to tide him over until he gets back home?

He certainly doesn’t look like an addict, and you don’t want him to be in pain. So what’s the harm in helping him out?

many patients — who may legitimately need narcotic pain medication — is falling on physicians who may not have the time or comfort level to treat them. And often, they don’t feel like they have a choice.

A lot of pain

“What’s getting lost here is the prevalence of chronic pain in this country,” Dr. J. David Haddox, vice president for health policy at Purdue Pharma, told RAM members in a November speech. Haddox cites the 2012 National Health Interview Survey that states 126 million U.S. adults experience some pain, 25 million experience pain daily and 23.4 million report “a lot” of pain.

Express Script’s study “A Nation in Pain” reported that:

- Nearly half of patients who took opiate painkillers for more than 30 days in the first year continued to use them for three years or longer.
- In addition, almost half of chronic opioid users took only short-acting medications — rather than longer-acting formulations — thus increasing their risk for addiction.
- America is hurting and patients need care. Are you treating your patients’ pain correctly and responsibly?

The problem is already here

Many people — including physicians — want to believe the opioid (and heroin) abuse epidemic is something that happens elsewhere. It’s in Appalachia, or it’s that case in Indiana where prescription medication abuse ultimately led to a surge in HIV and hepatitis C from shared needles.

But it’s happening here in Richmond, possibly with your patients and their families. “More and more of us are going to have a personal connection” to substance abuse, Virginia State Health Commissioner

Each day, 46 people die from an overdose of prescription painkillers in the U.S.

You know where this is going.

Opioid abuse is soaring. According to results from the 2010 National Survey on Drug Use and Health, an estimated 2.4 million Americans used prescription drugs nonmedically for the first time within the past year, which averages to approximately 6,600 initiates per day. In Virginia in 2014, deaths from heroin and opioid use outnumbered highway fatalities for the first time — 728 deaths from overdoses compared with 700 highway fatalities, mirroring a national trend.

The government is watching closely and taking action. And while that’s a good thing, many doctors are afraid of getting dinged.

With a dearth of pain medicine specialists, the task of caring for long-term conditions were prescribed potentially dangerous mixtures of medications during the same time period. Two-thirds of patients using these medication mixtures were prescribed the drugs by two or more physicians, and nearly 40 percent filled their prescriptions at more than one pharmacy.

- Nearly half of patients who took opiates for more than 30 days in the first year continued to use them for three years or longer.
- In addition, almost half of chronic opioid users took only short-acting medications — rather than longer-acting formulations — thus increasing their risk for addiction.
Dr. Marissa Levine said. In fact, more than 56 percent of Americans say they have a personal connection, according to a recent Kaiser Family Foundation poll. That number includes those who know someone who died from an overdose, have been addicted themselves or know someone who is, or know someone who took painkillers not prescribed to them.

Primary care pressures

Pain management has become an extremely sensitive topic for primary care physicians. It puts doctors on the spot, sometimes without concrete guidelines, afraid of doing the wrong thing as they do their best to treat a variety of pain issues. Too often, they feel, pain management doctors only want to provide costly procedures, then refer patients back to primary care for prescriptions and monitoring. Primary care physicians say they feel like they’re being asked to fix a problem that began with another physician’s prescribing of opioids and other painkillers. A couple of decades ago, physicians were encouraged to prescribe more; now they’re hearing that they’re overprescribing.

And some primary care physicians also privately express concern about the Board of Medicine’s policies and procedures, which they find laborious. “Most family practitioners know someone who got their hand smacked or lost their license because they were trying to help out a patient and wrote out a prescription for narcotics,” said Dr. L. Randolph Chisholm of Midlothian Family Practice. “If you don’t cross the t’s and dot the i’s and document everything, then you’re in trouble.”

Sure, there are abusers who doctor-shop trying to get their hands on medications. It can actually be easier in a metropolitan area like Richmond than in rural areas because of the concentration of providers, said Ralph Orr, director of Virginia’s Prescription Monitoring Program (PMP).

On the other hand, you might have a patient who had a back injury, got some pain meds and now can’t get off them. Or maybe she didn’t need that prescription after surgery but had it filled anyway and the teen-age baby sitter found it in the medicine cabinet.

Or maybe it’s that “friend” of a friend from out of town who needed a quick refill.

Painkiller abuse cannot be allowed to continue, and physicians play a key role in controlling it, said Levine, who’s part of the Governor’s Task Force on Prescription Drug and Heroin Abuse, a 32-member multidisciplinary group of leaders across the state. “It’s one of those issues where everybody has a role, and everybody has a piece of the puzzle.” The Kaiser Family Foundation poll reported that half of those surveyed rank prescription painkiller and heroin abuse as a top priority for government, just behind improving public education and making health care more accessible and affordable.

Consider our patient with back pain or one who’s had recent surgery. Often, a specialist or surgeon will prescribe the initial dose of pain medications appropriately, just as they are trained to do. But with a shortage of pain specialists, sometimes those same patients end up back with their primary care physician, demanding more pills.

Our addiction to painkillers

Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.

nearly 19,000
people died from prescription opioid overdoses in the U.S. in 2014.

1.9 million
Americans live with prescription opioid abuse or dependence, while 517,000 Americans live with heroin addiction.

24.6 million
people 12 or older (9.4% of the population) live with substance dependence or abuse.

about 75%
of opioid addicted patients switch to heroin as a cheaper substitute.

Is there a solution?

Dr. Stephen P. Long of Commonwealth Pain Specialists understands that proper pain management can be time consuming for primary care doctors and acknowledges the need for more pain specialists. “But I do think primary care doctors can feel comfortable treating these patients. I think they need to be careful about medication interactions, not just narcotics but everything. It goes back to taking a good, detailed history, asking about family and about substance abuse. There are basic drug screenings and psychological tests that are accurate predictors of abuse. And the PMP is a very effective tool.”

Under Virginia’s PMP, physicians with a valid license from one of the state’s health regulatory boards must register, allowing 24/7 access to all prescription records in the database.”

“Opioid,” continued on page 8
1. What is the role of pain management specialists in the care of advanced but chronic cancer patients? There seems to be significant reluctance in Central Virginia for any specialist other than Palliative Medicine, Oncology and PCPs to even assess pain issues as a result of malignancies. As a medical student rotating with a Pain Service, we routinely offered palliative pain treatments to cancer patients who were grateful for relief with interventions that avoided many of the effects of systemic agents. This provided them with the right balance to enjoy their last couple of years with improved quality of life. We do not see this happening here in Richmond. Even with patients willing to pay for these services, Why?

Answer: A qualified pain physician should be competent and willing to provide interventional and medical treatment for patients with cancer-related pain syndromes. The American Society of Clinical Oncology has a number of CME offerings online that aim to inform physicians of good pain management principles applicable to treating cancer-associated pain (http://university.asco.org/cancer-pain). I cannot offer an explanation for the situation you describe, other than to say that medical practice does have regional variation. Decreasing unwarranted variation in medical care is the focus of many quality initiatives, including ASCO’s Quality Oncology Practice Initiative® measures.” Source: ASCO.org.

2. In many ways, we are fortunate to have a wonderful tertiary care center and large medical systems in our backyard. However, what happens when pain management specialists in both non-profit and for-profit sectors, academic and private clinics “fire patients” for violating patient-provider compacts? Very complex pain patients have no one to turn to and the community doctors have nowhere to refer. Can patients really be “fired”? Any advice?

Answer: While the use of patient-provider treatment agreements have become more common, especially when opioid analgesic therapy is involved, presumptive violations should provide the opportunity for a therapeutic conversation between the prescriber and the patient. There are many reasons people may deviate from the terms of an agreement. The reasons may include using the medicine to treat a symptom other than pain or may signal the emergence or uncovering of a latent substance-use disorder. Events such as these should trigger counseling or a change in treatment focus. Source: FSMB.org

3. What is the latest information about the effect of THC on the adolescent brain? Is there an imminent danger to their future cognitive skills as THC becomes more legal and acceptable?

Answer: NIDA states that marijuana use can lead to addiction and that the risk is greater with the adolescent (ie, still developing) brain. Much of what we “know” about marijuana is based upon historical studies done when the cannabinoid potency of marijuana was less than it is commonly today. In addition, selective breeding has changed the ratio of cannabinoids from that commonly encountered in the past. The literature demonstrates impaired driving, which can be worsened with concomitant use of ethanol, and impaired critical thinking and memory functions that persist for days after exposure. Source: NIH.gov
The real question is how do we maintain the public confidence in our ability to regulate ourselves in a way that is reasonable and functional.

BY MICHAEL J. MENEN, MD

Dr. Menen is Chief Medical Officer of CJW Medical Center. He can be reached at Michael.Menen@hcahealthcare.com.

If patients have pause to contemplate their mortality in today’s highly regulated healthcare facilities, just imagine what must have gone through the minds of our ancestors. Most patients at the beginning of American medicine were at the mercy of a medical fraternity renowned more for the eccentricity of its cures than its efficacy. Professional societies began regulating medical practice in the U.S. by examining and licensing practitioners as early as 1760. Nonetheless, the education of physicians and the practice of medicine continued to be quite variable. “Proprietary” schools of medicine were loosely regulated with few requirements. Many were largely diploma mills.

To address the many abuses in medical education a national convention was held in 1846, Delegates representing 40 medical societies and 28 colleges from 22 states resolved themselves into the American Medical Association (AMA). Proposals from that convention included a standard code of ethics for the profession and the adoption of uniform higher educational standards for MDs, including courses of premedical education.

Board certification began in 1917 with the American Board of Ophthalmology as the first specialty board. In June of 1933, representatives from other pioneering specialties and the major physician, hospital, medical education and examination groups of the time met to establish a uniform system to administer board examinations. The result was the formation of the Advisory Board for Medical Specialties (today’s ABMS).

Initially, board certification was voluntary and intended to distinguish comprehensively-trained physicians from the more eccentric. Certifying boards felt it important to set high standards that would be credible with the public. Boards were considered a mark of excellence and professional achievement. Board certification is now virtually mandatory. Consumers have been educated to consult board-certified physicians, and board certification has become a required credential for new hospital privileges. Most health insurances prefer board-certified physicians for their networks.

More recently, boards have also become a method of insuring physician knowledge and capability in a rapidly evolving science. To promote lifelong learning, the ABMS agreed in 2001 to limit the duration of board certification in a process called Maintenance of Certification (MOC). MOC includes periodic recertification requirements and an evaluation of performance in practice.

As the requirements for certification and recertification have become more onerous, physicians have complained that they must spend thousands of dollars not only for the tests but for review sessions and time away from their practices. The American Board of Internal Medicine (ABIM) lists recertification costs of $2200 to $2500 over the course of 10 years. Many physicians maintain it actually costs much more when you factor in the cost of study materials and the time commitment — possibly as high as $20,000.

Additionally, many physicians note that recertification exams often feature esoteric questions about problems unrelated to the care they provide to their actual patients. Physicians also note that questions very often do not reflect current best practice, while others mention the questionable impact of repeated testing on the quality of care. According to the ABIM’s figures, the percentage of doctors passing the recertification test has steadily dropped. In 2010, 88 percent of internists taking the maintenance of certification exams passed; by 2014, that had fallen to 80 percent.

In pulmonary critical care the drop has been even more precipitous, 90 percent to 79 percent.

According to documents filed with the Internal Revenue Service, in 2001 — just as the MOC process was rolling out — the ABIM brought in $16 million in revenue, and its highest paid officer received about $320,000 a year. By June 2013, the ABIM brought in $55 million in revenue, and its highest paid officer made more than $800,000 a year from the ABIM and related ventures.

In response to fierce criticism that its MOC program had become too time-consuming, too expensive and irrelevant, the ABIM announced in September that it would consider replacing the exam with shorter, more frequent tests that physicians could take at home or in the office. Days earlier, the American Board of Anesthesiology said it would drop its 10-year MOC exam in favor of continuous online testing in 2016.

The National Board of Physicians and Surgeons (NBPS) has joined several other boards as an alternative to the Advisory Board for Medical Specialties. NBPS has a way to go in terms of being accepted, but it is making headway. Initially, NBPS will certify only physicians in internal medicine specialties, subspecialties and family practice. The cost is $169 for two-year certification, no matter the number of specialties. The NBPS website says the application takes less than 15 minutes to complete. Physicians maintain their status by completing qualified CME of their choosing.

However, the value of the alternative medical boards is unclear. Currently, many hospitals, insurers and regulatory bodies require physicians to pass MOC, and some physicians see “not” certifying as a threat to job security. Several other boards have been formed, but few are recognized by medical staffs and hospitals.

For decades, doctors took one exam, usually just after finishing training, to prove they had absorbed enough medical knowledge to treat patients. But this has changed over the years with the growth and cost of MOC tests, which many physicians see as irrelevant. Adding to their frustration, many doctors contend that all this testing has not been proven to produce better outcomes for patients. Nonetheless, our current board system has been recognized by health systems, hospitals, insurers and the public for decades as the board certification process and now MOC process that people place their trust in and as the pre-eminent forum of professional self-regulation.

What next? Well, there are many opinions. The real question is how do we maintain the public confidence in our ability to regulate ourselves in a way that is reasonable and functional?
“We’re winning” and “Medicare” are rarely uttered in the same sentence by physicians or those who manage their practices. But that’s exactly why nearly 100 physicians at OrthoVirginia are feeling bullish about BPCI, the acronym for Medicare’s Bundled Payment for Care Improvement.

In the second year of one of the programs launched by the Centers for Medicare & Medicaid Services (CMS), the arrangement has gone smoothly thus far for OrthoVirginia, which recently added 18 doctors when it merged with a practice in Lynchburg. The underlying reason, according to practice administrator Jim Perkins, is that unlike some government programs, there’s nothing in the arrangement that yanks away a doctor’s control of a patient’s care. “Nothing happens without a doctor’s order,” he explains. “The physician knows what things cost, and he or she can make the decision about the best use” of resources.

So taking part — along with many other orthopedic practices around the country — in the BPCI initiative “is not a hard decision because the patient benefits, and the data support it.” It doesn’t hurt that another orthopedic practice — Signature Medical Group in St. Louis — assumed the risk as the official “convener” of the BPCI initiative.

While noting “this wasn’t done out of love — but was a business decision,” Perkins quickly adds that he’s feeling some love when it comes to CMS’ game-changing payment innovations. “I love it — they’re letting us play the game. It’s not an ugly game. It’s an interesting game.”

Around the Academy, in-depth interviews with physicians, practice managers and healthcare executives reveal various levels of love, hate and points in between when it comes to playing the new “value-based” payment game with Medicare and with private insurers.

Some physicians say they’re playing along because they see little choice; others are fighting to maintain their independence as they see their colleagues getting bought out. But they all agree that if a program benefits their patients’ care, they’re willing to try it. Or as Perkins put it: “Incentivizing the doctor to do the right thing is a good thing.”

After the 2010 Affordable Care Act removed many legal obstacles to sharing patients, data and business practices, CMS wants “to create opportunities for [providers] to organize in different ways and do it legally,” says Mark Wysong, regional vice president for Strategic Pricing and Analytics, HCA in Virginia, Indiana, Kentucky and New Hampshire.

With its underlying goal of ditching the still-dominant “fee for service” model, CMS is saying, in effect, “We’re providing you seed money, and we’re going to provide you with a patient population and give you incentives” to find different ways to treat these different populations, Wysong explains.

This new business model “recognizes that in order to produce a different output” through the ACA, “They had to create a different set of economic incentives — one with improved focus on patient care, cost management, quality and metrics.”

One of the little-noted aspects of Obamacare is the extent to which CMS can try new things without getting congressional approval. If they work, great; if they don’t, they can “fail quickly,” as business analysts put it. So, in Wysong’s view — whether you’re a doctor, practice manager, hospital administrator or insurer — there’s good news in the alphabet soup of alternative payment models coming down the pike from Washington. “The ACO movement has created an environment where
businesses could form to create new incentives to care for populations.”

But deciding how and where to participate can be a daunting, time-consuming and financially risky challenge. Today, says Wysong, “The challenge for RAM members is understanding what’s going on. What do you need to do to position your business? Of course, what’s so hard for physicians is they’re seeing patients all day — it’s very hard for them to have the time and interest to understand the economics of it.”

Nonetheless, RAM members are in what Wysong calls “different states of change,” depending on a practice’s size, scale and access to capital.

One large independent practice making such a change is the rapidly growing OrthoVirginia, which toews the benefits of its shared savings program. Another approach is being tried by many Richmond-area primary care physicians and specialists who formed MD Value Care, one of CMS’ 333 Shared Savings ACOs.

The shifting dynamics help explain why HCA started its trailblazing Virginia Care Partners, a Clinically Integrated Network that focuses on achieving shared savings through private insurance contracts. And it’s why Bon Secours is pursuing a multifaceted strategy of private contracts and various ACOs and bundle payment arrangements to reward its doctors.

Today, physicians “are being encouraged with carrots to take on the risk. But in the future, they may not have as much leeway as Medicare shifts its payment incentives, and they’ll be penalized,” says Rick Mayes, associate professor of political science at the University of Richmond and co-coordinator of its Healthcare Studies program.

For larger specialty practices, it may be easier to enter into bundled payment pacts “because they’re big and can take lump-sum payments for a diagnosis,” he said. But for smaller practices, Mayes says, “the bigger problem is they don’t have all the infrastructure and personnel” in place “to handle all of the episodes of care.”

Which is why, he notes “most small practices — less than 10 physicians — are going to face serious challenges in the years ahead unless they have a sufficiently large clinic base willing to pay cash for much, or all, of their care.”

While it’s impossible to explore everything going on in this brave new world of care and compensation, here are some snapshots from around the Academy.

**MD Value Care**

Started in 2014, its physicians and practice administrators spent much of the first year “focused on quality data reporting,” said Ann E. Honeycutt, Vice Chairman of MD Value Care and Executive Director of Virginia Cardiovascular Specialists. “Year two has been getting specialists more involved to identify ways to improve care while managing costs.”

So, for example, specialists are spending more time keeping the ACO’s 13,400 “attributed patients” out of the emergency department and trying to avoid hospital readmissions. This has involved hiring a full-time care coordinator, a chief medical officer and making other changes to streamline the referral process between practice groups. This includes more proactive communications between PCPs and specialists.

“Our vision has been to figure out a way to support independent physicians, move the quality and cost needle in an effort to achieve the ‘Triple Aim,’ which focuses on improving the patient experience, health of populations and reducing the per capita cost of health care,” says Honeycutt, who now serves on the Academy’s board of directors.

The MD Value Care network has also focused on adding value to its members. Today, nine of its practice groups are participating in a new benefits consortium to provide health insurance options for the 1,100 employees of the practices.

“Of course, making so many changes has taken what Dr. Ken Zelenak of Commonwealth Primary Care calls “an enormous amount of time and resources” by board members and participants alike — in his case anywhere from two to three hours a day.

The reason: 33 quality indicators most of which apply to each and every patient, and some of which apply to patients based on their individual disease states. Simple, right?

Wrong. “You have to standardize patient flow and documentation from the front desk all the way through the end of the visit and to the follow-up visit,” explains Zelenak, who’s on MD Value Care’s board of managers and quality committee. So, for example, for a relatively simple sounding issue like documentation of a patient having a colonoscopy, Medicare requires the report be on file and reviewed. No credit is given for a patient reporting the procedure was completed or if the procedure report is missing from the primary physician’s file. The colonoscopy may have occurred a decade ago.

For the 24 physicians at Commonwealth Primary Care, this requires a heck of a lot of phone calls to other providers. The documentation workload is enormous,” often eating up much of his lunch hour, not to mention several hours or more at night.

MD Value Care has five primary care groups. Besides CPC, they are: Virginia Family Physicians, Dominion Medical, Lee Medical, Lee Davis Medical and Virginia Diabetes and Endocrinology.

Zelenak has also seen the professional toll the changing medical economic environment can take — whether on accepting new patients (a two- to four-week waiting period is now a three- to four-month wait) or on the retirement plans of older colleagues.

But at age 40, he adds with a chuckle, “The good thing for me is I’m a relatively young provider, and I don’t know any different.” All kidding aside, he says, “We keep doing this because it’s about your relationships with your patients. It’s not all about reimbursement. If we can deliver a better product and improve our relationships with our patients, then it will have been worth it.”

At Virginia Cancer Institute, Executive Director Tom Gallo agrees that better patient care is always the main goal for his physicians. Still, they want to stay ahead of the reimbursement curve as payments shift from volume-based to quality-based care arrangements.

Then there’s the matter of staying independent — was that a factor in joining the MSSP? “Absolutely,” he replies. “Our goal is to remain independent. We think this is the way we can provide the best quality and value to the patient. We did feel working with the other independents in the area would collectively strengthen our groups and improve the coordination of patient care.”

Though his cancer specialists didn’t reap any savings after the first year of the shared savings program, Gallo sounded unconcerned. “While it’s disappointing, we’re all looking forward to the future.”

“Games,” continued on page 12
Virginia Care Partners: A Clinically Integrated Network

“We’re the most advanced clinically integrated network in HCA. When we opened the door, we set the wheels in motion, and they have begun to roll,” said Margaret Lewis, Virginia’s former chief executive officer, proudly declaring the VCP’s success. As the VCP continues to grow, the real savings are beginning to be realized. In 2014, after total savings of $411 million in 2014, the VCP announced a reduction in the number of quality measures from 101 to 17 in the Cigna contract. In addition, VCP has shifted quality measures from the much-maligned Medicare PQRS to contract-specific measures. One of the advantages VCP brings to its physicians is the ability to negotiate a core set of quality metrics across multiple commercial contracts. Improvement will be tracked via claims submitted to an analytic and management tool — Crimson Population Risk Management — developed by The Advisory Board Co. Performance feedback, designed as educational, will be regularly shared with physicians to promote their success in the value-based contracts.

While more than 350 ACOs reported a total savings of $411 million in 2014, after paying bonuses the ACOs recorded A NET LOSS OF $2.6 MILLION TO THE MEDICARE TRUST FUND. In 2013, its first year of operation, more than half the VCP doctors reached $2.6 MILLION OF ACOs recorded million in 2014, after total savings of $411 million in 2014, the VCP announced a reduction in the number of quality measures from 101 to 17 in the Cigna contract. In addition, VCP has shifted quality measures from the much-maligned Medicare PQRS to contract-specific measures. One of the advantages VCP brings to its physicians is the ability to negotiate a core set of quality metrics across multiple commercial contracts. Improvement will be tracked via claims submitted to an analytic and management tool — Crimson Population Risk Management — developed by The Advisory Board Co. Performance feedback, designed as educational, will be regularly shared with physicians to promote their success in the value-based contracts.

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As a family physician, each time I see a patient I have a number of issues I try to cover. I see how my patients are doing with their chronic medical problems, assess for side effects of treatments, update refills and order necessary labs and tests. I also try to handle any current or newly developed problems that might have arisen since a patient’s last visit. Finally, given the long-term relationship this process is seen most clearly during well child visits for our pediatric patients. An important part of these visits is providing anticipatory guidance, which means we talk about the child’s current development, discuss what developmental milestones are coming up (moving from crawling to walking, speech development, social interactions and new language skills) and what safety measures need to be considered — being sure to childproof the home, avoiding choking hazards and the like.

Central to all this work is the physician-patient relationship. When I work with patients, my principle responsibility is to do right by them, provide the care they need and avoid interventions that are not needed and that could be harmful. I partner with patients to share the decisions as to how best to proceed and advise what benefits and what risks might be present in any decision. My commitment to my patients’ health builds confidence and trust and makes our physician-patient partnership ever stronger.

So imagine a scenario in which I am unable to provide the medical care that I believe is needed or the anticipatory guidance that is appropriate because a legislature has decided that it knows better than my patient and I do. Imagine that legislation dictates what I can or cannot share with my patient or that legislation dictates what I must say, even to the extent of requiring me to give my patient medically inaccurate information. If we value our relationship with our patients and if we feel our obligation to do right for and by our patients is central to who we are as physicians, how can we accept this legislative intrusion into this privileged doctor-patient relationship?

This may seem far-fetched, but it is not. Already in Virginia, the legislature has dictated what we must tell our patients under certain conditions.

Already in Virginia, the legislature has dictated what we must tell our patients under certain conditions.

This is central to what I do, I look at any preventive care that might need to be addressed and counsel my patients on areas where their choices may impact their health. We talk about smoking and tobacco use, alcohol use, STI prevention, using bike helmets and seatbelts and other important issues that can help avoid injury or illness.

Mark Ryan, MD, is a family physician with Virginia Commonwealth University Health System. He may be reached at mark_hehman_ryan@yahoo.com.
tions. In 2013, the General Assembly passed, and the governor signed into law, a bill that requires any physician ordering Lyme disease labs to provide a written advisory to patients about the potential issues with the labs. Not only that but the legislation also contains the specific language physicians must use in this advisory. There is no choice: Patients must receive this written information. It’s the law.

As someone who values the doctor-patient relationship, and is fortunate to teach this topic at the VCU School of Medicine, I believe physicians should counsel patients on issues such as this. However, I do not agree that the exact and specific language of this counseling should be codified into law. As Dr. Sterling Ransone, past president of the MSV, worried in a 2013 interview, “It’s a dangerous slide by the General Assembly. We don’t feel it’s the General Assembly’s job to codify the practice of medicine. My worry is, ‘What is next? What is the next disease du jour?’ Emotion frequently rules the day.”

Another example of legislative overreach in Virginia is the requirement that any woman seeking abortion services must undergo a transabdominal ultrasound before the procedure. Initially, this legislation could have required a transvaginal ultrasound, but this option was removed during the legislative deliberations around the bill. However, the law was passed and signed into law, forcing women to show up for a legal healthcare service in the commonwealth of Virginia to undergo a medically useless test — even if their physician does not see any need or if the patient attempts to refuse.

Sadly, this legislative intrusion is not unique to Virginia — it is an example of a national trend of legislators deciding that they know the practice of medicine better than physicians and dictating medical care accordingly. A new report released in October 2015 — and co-authored by the National Physicians Alliance (NPA), the National Partnership for Women and Families, the Natural Resources Defense Council and the Law Center to Prevent Gun Violence — outlines the extent to which legislatures have intruded into the practice of medicine and the sanctity of the doctor-patient relationship. Some examples:

- The chemical solutions used in hydraulic fracturing (“fracking”) have been identified as trade secrets whose specific chemical components may be known to a limited number of people. The treating physician may be informed of this information, for example, but be unable to tell his/her patient to which chemicals patient may have been exposed.
- A number of state legislatures have intruded in the areas of reproductive health and abortion services. States may require unnecessary ultrasounds (as is the case in Virginia), and in some cases if a woman declines to view the ultrasound, the ultrasonographer is required to describe the image to the patient. Other states require abortion providers to give medically unfounded or inaccurate counseling.
- In Florida, asking patients if there is a gun in the home — an important part of pediatric well child visit anticipatory guidance, given the risk of harm that results from firearms in a home, especially if not stored safely — can result in a physician facing a fine and/or losing his/her medical license.

No matter their politics, I trust that all physicians would agree that the obligation physicians have is to care for their patients in the way that best meets their patients’ needs. I also trust that all physicians would agree that legislatures — state or national — have no role in dictating the nature of medical care that occurs in the exam room. Every physician I know bristles at insurance companies imposing their overview on our medical decisions. We struggle to work with medication formularies, we complain about the need to request prior authorizations for treatments, imaging or procedures, and we argue over third-party reviewers who deny our requests. How much more upset should we be, then, when the very foundation of trust between physicians and patients is threatened?

The NPA has led the medical community’s response to this issue as a co-chair of the Coalition to Protect the Patient-Provider Relationship (coalitiontoprotect.org). NPA has been joined in this coalition by multiple medical organizations which together represent the vast majority of American physicians, including the American Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists and the American Osteopathic Association. In Virginia, the coalition’s work can build on the existing policies of the state’s constituent chapters of these national organizations, including the Medical Society of Virginia’s focus on protecting the physician-patient relationship.

Physicians’ ability to provide evidence-based, patient-focused care is under threat across the United States, and Virginia’s General Assembly has already forced its way into our privileged obligation to our patients. As we move through the 2016 legislative session, we must all be mindful of this risk and work with the MSV and our respective state specialty societies to preserve our special place in patients’ lives and continue to help them live the healthiest lives possible.

(Disclosure: Dr. Ryan is the Vice President of Communications for the National Physicians Alliance. His comments are his alone and do not necessarily reflect the opinions of VCUHS.)
"Imagination is more important than knowledge," is a quote attributed to Albert Einstein. As a graduate of the Albert Einstein College of Medicine in New York City, I frequently quote Einstein and, in this case, sheepishly beg to differ as it relates to health improvement. I believe both imagination and knowledge are important (though not sufficient) to advance our health system here in Virginia. I chose the term health system and not healthcare system because health care, although important, is only one of those factors that significantly influence our health.

In 2007, Steven Schroeder wrote in the New England Journal of Medicine Shattuck Lecture article, "We Can Do Better – Improving the Health of the American People," about the five domains influencing health: genetics, social circumstances, environmental exposures, behavioral patterns, and health care. “When it comes to reducing early deaths, medical care has a relatively minor role... the single greatest opportunity to improve health and reduce premature deaths lies in personal behaviors.” In addition, Schroedr highlighted social circumstances as another significant contributor to premature death.

As clinicians, I know you know this intuitively. To create a health system that is designed in consideration of all these health factors will require our imagination, knowledge and a strong will to persist in our efforts to intentionally create what I refer to as “health promoting systems.”

I am writing today because I believe we have an important opportunity to align our efforts for the benefit of all people in Virginia. Collectively our efforts could positively influence those issues that most impact our health. In doing so, we would also be improving clinical effectiveness in ways not yet considered. In my opinion, right here in Central Virginia and throughout the commonwealth, we have the components for such an effort. In particular, there’s an emerging new leadership that seeks to envision such a system, those involved will need to draw on their knowledge, wisdom and imagination. Physician involvement in these efforts will be crucial.

So imagine with me that through aligned effort we will create community systems that change the context in which people live and, in so doing, intentionally design our community systems for health outcomes. This is critical because personal behaviors can be influenced by context and some options may not be available to people who live in areas with decreased opportunities to be healthy. As personal behaviors change, so do social circumstances. Through visualization we can unleash the creativity and innovation needed to build on our knowledge and wisdom gained from experience. So, please imagine with me:

The year is 2020 in Richmond, Virginia. Your patient Mr. George, a 54-year-old retired Marine and former smoker, suffers from essential hypertension and COPD. He has a history of depression and was homeless previously. But due to the governor’s initiative to end homelessness for our veterans, he became eligible for housing. An analysis of the data and a return on investment analysis resulted in important additional policy changes.

These policy changes resulted in better health and productivity for Mr. George and people in similar situations. The policies implemented three years previously provided housing and also included wraparound social supports. Those social supports were instrumental in ensuring access to mental health services for his depression. The local community health assessment, performed collaboratively in this

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Imagine

BY MARISSA J. LEVINE, MD, MPH, FAAFP

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Virginia will become the healthiest state in the nation and all the people will have a greater opportunity for health and well-being.
part of Richmond, identified the community health needs as well as the available assets, thereby characterizing the gaps. This community-driven process helped identify strategies to fill those gaps, including the need for integrated healthcare practices, in addition to many other opportunities.

In addition to building on the governor’s initiative, a local health system was able to use the assessment to receive grants and tax incentives to build, following an evidence-based model, an integrated care center in his neighborhood. This is where you located your practice. As a result, Mr. George received whole-person care for all of his issues: oral, behavioral and physical health. Also, as a smoker, he was encouraged, supported and received guidance from you and your staff to access the tobacco quit line and work with his neighborhood community health worker resulting in his successful smoking cessation.

Policymakers at the state and local levels realized, as a result of the analyses made available to them, that the quit line and community health worker programs were true investments that more than paid for themselves. In fact, the business community became a supporter as it helped assure a healthier workforce. As the healthcare system increased its effectiveness due to the community’s collaboration to prevent unnecessary readmissions, those savings were invested in the front end on these types of evidence-based preventive initiatives. These investments — leveraged from other sectors — resulted in a sustainable community system of prevention and increased the opportunity for health for all. Mr. George and many others benefited greatly from those policy changes and local efforts. In addition, the younger generations were already showing signs of better health outcomes, thereby beginning to break the vicious cycle of poor health so prevalent in this part of Richmond. As a physician, you realize the realignment of community assets and processes have taken a significant burden off of your practice, resulting in better health outcomes for your patients. Given the value-based payment reforms, your practice’s financial viability is much stronger and you were able to add additional primary care providers. These providers were easier to attract partly because of the support systems in place and also because of the expanded residency positions made available in Central Virginia and elsewhere around the state — an example of our focused investment of savings.

Also, Mr. George, with a BMI of 31 just three years ago, was the beneficiary of these collective impacts. For example, an effort initiated by local citizens and business ensured a “complete street” approach in his neighborhood and community policing which resulted in a safe environment in which he could walk to work. The wraparound services noted previously identified skills he had developed during military service and provided job training to aid his entry into the workforce at a business also newly housed in his neighborhood in the east end of Richmond. The East End had become a thriving incubator for innovative entrepreneurial businesses that focused on hiring local residents. Mr. George’s BMI is now 26, his blood pressure is controlled and he’s never felt better. He feels more in control of his own health and is motivated to stay healthy.

And you, as Mr. George’s clinician, have access to all the information necessary to evaluate his status and connect to the necessary referrals and consults. The health information exchange provides you seamless, bidirectional communication and alerts you to Mr. George’s access to other entities such as the local ED. Your EMR is linked to the community resource app that seamlessly identifies those resources available based on any identified social or health need and provides community prevalence data at the census tract level. So today when Mr. George presents with cough and fever you are one step ahead because your EMR’s public health portal has alerted you to a small cluster of Legionella pneumonia cases in his neighborhood.

Thank you for imagining with me! I know it may be a rosy vision, but we can do better. Together we will do better. I look forward to our shared leadership toward creating health-promoting systems in Virginia and building communities replete with opportunity for health for all its residents. Through our aligned collective efforts, Virginia will become the healthiest state in the nation and all people will have a greater opportunity for health and well-being. The many Mr. (and Ms.) Georges of Virginia are counting on us! 

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Goodbye SGR! What’s next for Medicare providers? MACRA!

MACRA pushes the value agenda and forces physicians to choose how they get paid!

BY ANN E. HONEYCUTT

The road to health care transformation is anything but smooth — it continues to wind, split, and dip in new and unexpected ways. It won’t be enough to simply buckle up for the very bumpy ride; physicians and organizations that want to thrive in the value-based world need to prepare for the trip now — research the best route to take, weigh the options, plan for detours and anticipate the unknown.

Last April, the U.S. House and Senate passed the Medicare and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA). The bill had a majority of support in both the House and the Senate, with a price tag of $214 billion. MACRA has four key elements, with the overarching goal of reducing fee-for-service payments, establishing a network for rewarding clinicians for value over volume, and streamlining quality reporting.

Although many details about MACRA are yet to be determined, it will (in absolute terms) force a migration away from fee-for-service reimbursement and push health care toward its goal of achieving the triple aim of high-quality, low-cost care with an exceptional patient experience. MACRA advances the movement away from payment for volume and replaces it with a system that ties payment to mandates for quality, outcomes, and efficient care; it achieves this with the introduction of the Merit-Based Incentive Payment System (MIPS) and the alternative payment models.

MACRA is largely focused on furthering the value agenda under the Affordable Care Act. The initiatives created by the current value-based modifier program (also known as physician value-based purchasing program), along with the physician quality reporting system (PQRS) and Meaningful Use, will sunset on December 31, 2018. After that, physicians will be faced with deciding between following the guidelines for participating in MIPS or choosing to be in an Alternative Payment Model (APM). Both options pose financial savings with misvalued codes. The clinical practice improvement modifier program (also known as APM) will be defined to mean any physician value-based purchasing program.

What does this mean for you? First, eliminating the long-standing “sustainable growth rate” should stabilize payments to physicians over the next five years with small increases of .5 percent every year starting July 2015 until 2019 if CMS identifies savings with misvalued codes. The small increase was meant to assist with the transition to a new payment system. For the following six years (2020-2025), the budgeted increase will be zero percent, but physicians could earn a bonus starting at 4 percent and increasing to 9 percent based on performance in four categories within the MIPS payment system.

Merit-Based Incentive Payment System

Although many unknowns remain, the new law means that MIPS will be one of two pathways that physicians may choose in terms of how they will be paid. The new incentive payment system, MIPS, will eliminate bonuses from three current programs but will incorporate many of the same elements into the composite score. MIPS will begin after 2018, impacting payments effective Jan. 1, 2019. The MIPS payment adjustment is calculated for each eligible professional based on four categories: quality, resource use, clinical practice improvement and meaningful use of certified electronic health record technology. The proposed details are illustrated in the chart below.

MIPS payment adjustments would be determined for a year and would result in differential payments reflecting the composite score. MIPS is intended to be budget neutral.

- Scores at threshold would receive no adjustment
- Higher composite scores would get higher adjustments, and composite scores below the threshold would lead to negative adjustments.
- Adjustment factors will be either positive, negative or zero

What are these categories based on? The quality portion of the score may be based on measures currently used in the value programs. Resource use will rely on data similar to the value-based modifier but with some significant changes (such as including Part D drug information). This category does allow for attribution and risk-adjustment methodology. It is intended that meaningful use measures will continue to be utilized to create the scoring for the category. Finally, clinical practice improvement will be based on access, population management, care coordination, beneficiary engagement, patient safety, and practice assessment. This critical component of MACRA is intended to get the Medicare beneficiary actively involved in the care process.

Alternative Payment Models

Providers who are exempt from MIPS would include eligible professionals who would be qualifying APM participants or partial qualifying APM participants as defined below.

The term alternative payment model would be defined to mean any of the following:

- A model under the Center for

MIPS Composite, Year 1

- 25% EHR Meaningful Use
- 30% Quality
- 15% Clinical Practice Improvement
- 30% Resource Use

Meaningful Use weight may be adjusted down to 15 percent if 75% or more EPs are meaningful users

Ann E. Honeycutt is Executive Director of Virginia Cardiovascular Specialists and a member of the RAM Board of Trustees. She can be reached at (804) 521-3801.
When you win the fight against cancer, every day is a victory.

Meet Ashley. She’s a runner, wife, and thanks to Virginia Cancer Institute, a breast cancer survivor. Her team of award-winning oncologists at Virginia Cancer Institute worked together to give Ashley the power and the treatment she needed to win the fight against cancer. These doctors included Richmond Magazine’s Top Docs for Oncology, and Our Health’s Best Bedside Manner award recipients.

See Ashley’s story firsthand at vacancer.com
Physicians should be somewhat familiar with the National Practitioner Data Bank. Created under the federal Health Care Quality Improvement Act of 1986, the Data Bank was intended to give medical staffs useful information about physicians whose competence has been found wanting, as demonstrated by hospital medical staff disciplinary actions, malpractice payments and licensure actions. But, like many professional liability insurance companies (such as The Doctors’ Company) reporting payments made on claims of malpractice. The bulk of the reports come from hospitals, which are required to report actions that adversely affect physicians’ medical staff membership or privileges for longer than 30 days; that number is about to increase because of changes made to the Almighty Guidebook.

The Guidebook has undergone changes only a few times since it was first published by the federal Centers for Medicare & Medicaid Services more than 20 years ago. Some changes were necessary because of changes in the law, such as those adding reports of criminal and civil sanctions. The latest Guidebook amendments were announced in 2014 and made open to public comment. The final changes were published in April 2015. The 2015 Guidebook changes regarding hospital adverse actions are nothing short of alarming!

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What you don’t know can get you reported

By Elizabeth “Libby” Snelson

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The Almighty Guidebook!

The Health Care Quality Improvement Act, like many complicated statutes, gave rise to regulations when and what to report. Consequently, the Guidebook is very influential as to what gets sent to the Data Bank, even though it does not have the force of law or regulation.

Reporting entities include state medical boards (such as the Virginia Board of Medicine) reporting actions against physicians’ licenses and professional liability insurance companies (such as The Doctors’ Company) reporting payments made on claims of malpractice. The bulk of the reports come from hospitals, which are required to report actions that adversely affect physicians’ medical staff membership or privileges for longer than 30 days; that number is about to increase because of changes made to the Almighty Guidebook.

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Surrender!

There is nothing new about the Data Bank requirement that a surrender of clinical privileges or medical
staff membership during an investigation is reportable. Another well-intended rule, the idea was to stop the common circumstance of plea deals, whereby hospitals finalise doctors into losing their clinical privileges in exchange for not getting reported. The new Guidebook significantly expands the parameters of this rule in two ways.

First, the Guidebook takes the idea of “surrendering” privileges in new directions. Under the 2015 changes, not requesting privileges for another term is a “surrender.” Thus, the physician who decides not to renew obstetrical privileges after 30 years of delivering babies, just because she wants to work a more predictable schedule, has surrendered privileges by not checking that box on the privilege renewal form. Remember, privileges only last for a two-year period. Letting them expire should not be a “surrender,” but an ongoing investigation renders a non-action on no-longer-existing privileges reportable. The Guidebook changes would also categorize taking a leave of absence as surrendering privileges. Even though neither action occurs as part of a deal to avoid reporting, this is immaterial under the new Guidebook.

Second, the Guidebook significantly expands the parameters of “investigation.” Now, any inquiry into a physician’s competence or conduct is an “investigation.” The common practice of defining in medical staff bylaws precisely when an investigation begins and ends no longer applies. Thus, a janitor expressing a concern to a medical staff leader equals the beginning of an investigation. Moreover, the investigation need not be at all related to the privileges surrendered to amount to a reportable event. Bylaws should also clearly identify when investigations begin and end. Compliance with the Guidebook bylaws provides protections for former members to be provided with notice whenever an investigation is initiated. At any juncture that could be interpreted as a surrender of privileges, physicians should be provided with written disclosure as to whether an investigation is underway and what the ramifications of taking a leave of absence or actual relinquishment of privileges will be if there happens to be an investigation going on at that time. Bylaws should allow for members to be provided with notice of an investigation for a surrender to trigger a report. Adherence to this interpretation in light of the new expanded versions of “surrender” and “investigation” seems designed to ensure useless Data Bank reports. At least if physicians are aware that an investigation is underway, they can hold off relinquishing clinical privileges or taking a voluntary leave of absence until the investigation is closed.

**Act up: What physicians can do!**

Hospital reports to the Data Bank should be based on the peer review process laid out in the medical staff bylaws at each and every hospital. Every medical staff should build protections into their bylaws. For example, the bylaws should provide for members to be provided with notice of an investigation. For ex-

**Surprise! No notice required**

There is also nothing new about the Data Bank position that the physician does not have to be aware, much less formally notified, of an investigation for a surrender to trigger a report. Adherence to this interpretation in light of the new expanded versions of “surrender” and “investigation” seems designed to ensure useless Data Bank reports. At least if physicians are aware that an investigation is underway, they can hold off relinquishing clinical privileges or taking a voluntary leave of absence until the investigation is closed.
Credentia ling is the process in which a practitioner’s education, training, work history and other information are verified through a primary source. Each healthcare organization that extends privileges to a practitioner is not only morally obligated but also legally responsible for ensuring that individuals on medical staff are qualified and competent to render patient care. This means any licensed independent practitioner (LIP) must go through the credentialing process before ever seeing a patient. But what about a primary source? Yes, it is a requirement of all accrediting bodies (including The Joint Commission, CMS, DNV, HFAP) that credentialing verification must be obtained from the primary source. What does this mean exactly? It means that verification of medical school must be obtained directly from the medical school where the practitioner obtained a medical degree or from a designated equivalent source such as the AMA profile (but only if the hospital’s Bylaws, Rules & Regulations and Policies & Procedures allow for use of equivalent sources).

Is credentialing that important? Putting the pieces of the credentialing puzzle together offers a picture of a practitioner’s competency to practice medicine. Usually there are no “red flags” or issues; however, a trained medical staff professional (MSP) knows how to spot when a piece of a puzzle is out of place or missing. A worst case scenario is what occurred in Texas when Dr. Christopher Duntsch killed or maimed at least 15 patients. Although he had been regarded as a danger to patients by staff, he was able to move between hospitals in the Dallas area and continue harming innocent patients.

A thorough and clearly defined credentialing process can help weed out bad practitioners from entering your hospitals and your communities. There are countless stories of how practitioners slip through the cracks in the system when the credentialing process isn’t adhered to or shortcuts are taken. And consider this as well: Late last year a circuit court judge in South Dakota ruled that even credentials committee members can be held liable for approving privileges for a provider when failing to properly credential doctors. Negligent credentialing lawsuits can cost millions of dollars to defend — and millions more in payouts! In 2014, the National Association Medical Staff Services (NAMSS) issued a white paper, “Ideal Credentialing Standards,” which identified 13 data elements that form the basis of a good credentialing process and have been established as best practice. Primary source verification of the following elements should be obtained on every applicant when applicable:

1. Proof of identity
2. Education and training
3. Military service
4. Professional licensure
5. DEA registration and state DPS and CDS certifications
6. Board certification
7. Affiliation and work history
8. Criminal background disclosure
9. Sanctions disclosure

Those of us who have been doing credentialing for some time know from experience that primary source verification is vital to patient safety.
Some of these data elements are mandatory by CMS and other accrediting bodies, while others are not. However, should litigation arise over negligent credentialing, credentials committees and staff could be responsible not only for what they knew but also for anything they should have known or that “a reasonably prudent hospital” would have known. Therefore, the credentialing process has become increasingly elaborate, and in an effort to keep up with technology, additional stopgaps have been put into place. No longer is a copy of your professional license sufficient for verification purposes. For example, today most states now have online verification sources to verify licenses.

What can I do to make my credentialing go smoother/quicker?

I am often asked by providers or their staffs, “Why does the process take so long, and what can I do to make it faster?” Well, often the process could have been faster for the provider if they had put more effort into carefully completing the application.

Applications that are completed in their entirety with complete start dates and with full contact information will undoubtedly be turned around faster. Anytime information isn’t disclosed on the application and is discovered during the credentialing process, it will add to the turnaround time.

Furthermore, if more time must be spent searching for contact information for references and affiliations, this too usually slows the process. So be sure to identify all gaps greater than 30 days in your work history. Any information that is requested on the application is requested for a specific purpose to satisfy an accreditation standard or policy. Delays are typically caused by us having to ask for additional information, sending requests to incorrect places because complete information was not provided or when incorrect information was provided. In other words, the applicant holds the key to a quick turnaround time.

What does CCVS have to do with it if it is the hospital’s responsibility?

The Academy created CCVS in the mid-1990s at the request of community physicians who were under pressure to obtain medical staff privileges but found the credentialing process was

“Credentialing,” continued on page 24

1 out of every 100 U.S. doctors is responsible for 32% of malpractice claims that result in payments to patients.

“Credentialing” continued from page 23

lengthy and cumbersome. CCVS was able to work with the hospital systems and centralize the credentialing process so that the primary source verifications only have to be obtained once and shared among the multiple facilities.

We’ve been able to take what was once a 90-day turnaround process and push it down to under 30 days in most cases by implementing a systematic yet detailed approach. Practitioners are able to move from system to system and static information such as education and training never has to be reverified as long as they are applying at a facility that partners with CCVS.

But really it is all about patient safety?

We do this important work because we care about patient safety. We take seriously our responsibility to identify red flags and any potential issues from the very beginning. And those of us who have been doing credentialing for some time know from experience that primary source verification is vital to patient safety. Any MSP can tell you a story from the near miss or the time he or she was able to identify a “bad apple” and saved the day. While such moments are rare, it is our professional duty to make sure the “bad apples” do not slip through the cracks and enter our healthcare facilities. After all, would you want that practitioner treating one of your family members?

REDUCING REDUNDANCIES

In 2012, CCVS took further steps to reduce redundancies with our Provider Enrollment program. This allows CCVS to use information on your hospital application to manage your insurance enrollment process. So whether you’re starting a new practice or are an established one, CCVS streamlines the application process to eliminate duplicate efforts! For more information, contact Tiffany Johnson at tjohnson@ramdocs.org or call her at (804) 622-8140.

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