

# VITAL SIGNS



MASSACHUSETTS  
MEDICAL SOCIETY

Every physician matters,  
each patient counts.



The Business of Being a Physician

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## Patient Experience: The Metric You Can't Ignore

BY KERRY ANN HAYON  
PPRC MANAGER

It feels like the era of patient experience has arrived. Never before has this complex intangible been so widely discussed and scrutinized. We all know the rules about a welcoming waiting room and a helpful and polite receptionist. But what about the trickier aspects of managing your patient's experience with your office from the first phone call to the post-exam follow up?

We know that patients are increasingly likely to be outspoken about negative experiences they've had versus positive ones, especially on social media networks like Facebook, Twitter, and other online forums. And with a strong emphasis on patient

*continued on page 3*

## Three Keys to Success in the New Practice Environment

BY DEBRA BEAULIEU-VOLK  
VITAL SIGNS STAFF WRITER

Maintaining a small- to mid-sized practice has become more of a challenge than ever before. The burden of running a small business, combined with other market changes, has contributed to a 75 percent increase in the number of physicians employed by hospitals nationwide since 2000, according to research from the Medical Group Management Association.

Closer to home, the 2012 *MMS Physician Workforce Study* showed that just 38 percent of respondents were self-employed at private practices, while 62 percent worked for group practices or hospitals, or were considering making the switch from self-employment.

For this issue of *Vital Signs*, we spoke with doctors practicing in small- and medium-sized practices about their experiences and perceptions.

Physicians do need some sort of business understanding, said Paul Bergeron, M.D., "at a minimum to understand what you don't understand of the business." In other words, doctors need to at least

understand what their business limitations are and corral resources appropriately.

### >> Business Knowledge

According to Dr. Bergeron, chief medical officer of Central Massachusetts Independent Physician Association, LLC, the resources provided by an IPA can provide physicians a substantial advantage in navigating issues such as ICD-10 conversion, providing performance and utilization metrics, human resources functions, and more.

"The biggest misconception is that an IPA is solely a contracting vehicle," he said. That definition may have been more accurate in the past, but changing times, particularly with the advent of risk-based contracts, forced IPAs to transform themselves into organizations with a more robust infrastructure.

As a result, IPA members have an opportunity to preserve much of their day-to-day autonomy while benefiting from the IPA's in-house and outsourced expertise and resources, Bergeron says.

*continued on page 2*

## Find Your EHR Adoption Sweet Spot

New MMS Best Practices Guide, CME Class Coming Soon

BY LEON BARZIN  
MMS HIT DIRECTOR

A 2013 MMS survey found that among the almost 80 percent of Massachusetts physicians with access to an Electronic Health Record system, a full 66 percent reported that using a system slows down their practice of medicine. Another one-third indicated a related initial decrease in revenue.

EHR-associated technology challenges are further intensified by other upcoming innovation mandates such as ICD-10, Meaningful Use Stage 2, and State HIway connection.

Responding to these dizzying transformations, the Committee

on Information Technology and MMS staff set to work developing a guide to EHR success that will be available to all members beginning in early April. The *MMS Guide to Health Information Technology: Best Practices, Checklists, and Pitfalls in Connecting for Better Health* will include a comprehensive and up-to-date look at the elements which lead to successful implementation and use of these technologies.

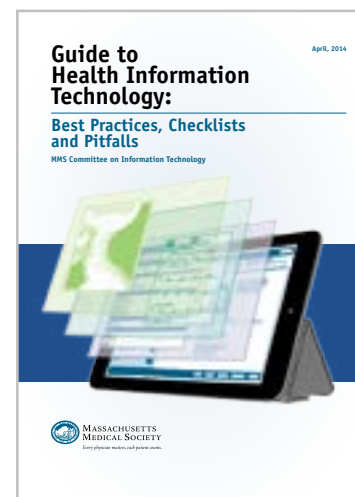
Drawing from a wide variety of sources, including personal experiences of some of our pioneering members, the guide provides many recommendations on EHR adoption and use in Massachusetts,

including best practices, pitfalls, checklists, and other resources.

The Committee on Information Technology will also host a CME conference from 8:00 a.m. to 2:00 p.m. on April 30, 2014, at MMS headquarters in Waltham, covering many of these topics in a lively interactive format.

To reserve your copy of the guide or receive further information on the conference, send an email to [lbarzin@mms.org](mailto:lbarzin@mms.org).

For ongoing information on HIT in Massachusetts, subscribe to the free MMS e-newsletter on HIT topics, the *ARRA Advisor*, at [www.massmed.org/newsletters](http://www.massmed.org/newsletters).



## PRESIDENT'S MESSAGE



### Our Business as Physicians

We have devoted the March issue of *Vital Signs* to exploring a special theme: The Business of Being a Physician.

Frankly, it isn't a topic most of us planned on contemplating during our careers. Long years of training and residency were supposed to be about serving medicine and our patients, not anyone's financial bottom line.

Times have changed. We cannot pretend that we can divorce ourselves from the financial realities battering the health care industry.

Reimbursements to providers are squeezed to the breaking point. We are told, repeatedly, to do more with less. But new payment models will not work for every practice setting. Every aspect of care will be reported, scrutinized, and measured — then reimbursed according to cost accounting standards often established by non-physicians.

We must make difficult decisions about how to manage our own careers. Physicians are asked to take on ever more financial risk — often without the infrastructure and experience to do so. We must consider whether to give up on independent group or small practice in favor of employment. How will we best protect ourselves and our patients under all the conceivable scenarios associated with the transition to new payment models?

I feel the MMS is in a unique position to support Massachusetts physicians by providing the resources and forums for physicians to share experiences. I hope you will continue to find valuable information and resources for your practice now, and in the future.

— Ronald W. Dunlap, M.D.

### New Practice Environment

*continued from page 1*

For MMS Assistant Secretary Treasurer Alain Chaoui, M.D., F.A.A.F.P., working with a qualified business manager is crucial to his success as a solo primary care physician at Family Medicine North in Peabody. "I concentrate on the medicine part of my practice, and I completely entrust the business of the practice to the practice manager," he said. "My business manager bounces important things off of me and we meet regularly to make sure the boat is floating."

Because of the high stakes of the management role, physicians should hold out to hire the right person for the job, notes James Demetroulakos, M.D., an otolaryngologist with North Shore ENT, a six-doctor independent practice with offices in Beverly and Danvers. "You have to have someone who is very organized, who knows their responsibilities and knows when to ask the advice and counsel of the partners... and also being able to engage our outside consultants for things that they don't know."

#### » Flexibility

"We live in an incredibly dynamic environment," said Dr. Bergeron. Physicians not only need to keep up with regulatory changes, such as Chapter 224 payment reform legislation passed in 2012, but also to embrace more cultural movements such as patient-centered care.

"Staying static is a recipe for disaster," said Dr. Chaoui. "You need to evolve with the times in terms of electronic medical records, having patients access their information, partnering with patients in their care, and

engaging the patient in decision making."

But in the midst of constant health care changes and trends, what guides Dr. Chaoui's compass is a constant focus on his patients. In fact, some of the best advice he's gotten about running his practice has come from the patients themselves, he said. For instance, based on patient suggestions, Dr. Chaoui recently launched a Facebook page for

*"We live in an incredibly dynamic environment"*

— Paul Bergeron, M.D.

his practice to help inform patients of news such as flu clinics and weather-related closings. He's also used data from small patient surveys to help fine-tune processes such as reminders for annual physicals.

#### » Entrepreneurial Spirit

Of course, the higher autonomy and control that many doctors associate with private practice does not come without a tradeoff.

Even with the benefits of belonging to an IPA, Dr. Bergeron says running one's own practice is challenging. "Unlike with the employment model, HR, payroll, billing, IT — you own all of that. It's not somebody else's responsibility. Even if you delegate it, ultimately the buck stops with you," he said.

"If someone just wants to get a paycheck and wants someone else to inform them of what their expectations are, contractually and otherwise, and doesn't want to take on the risk of running their own business, they are better off in an employed model," said Dr. Bergeron.

Despite the balancing act required to provide medical care and run a small business, Dr. Demetroulakos said the two tasks are not mutually exclusive. "Keeping a well-run office helps in patient care," he said. "And the policies that we put in place align with goals to help patients — so that actually enhances the patient experience."

Dr. Chaoui is careful to note, however, that working as an employed physician isn't necessarily easier, it's merely different. Physicians need to have courage, he says, whether they're employed by a group or in a small practice. "It's a myth that being in a small practice is difficult. It's difficult to be in practice, period. But being independent isn't as scary as you think. There are resources available to help you succeed."

As mentioned previously, resources not to be overlooked include the patients themselves. "I believe that the secret of our job is to keep your eye on the ball. If you focus on the patient, the patients will appreciate it, and this is a big part of any successful practice," Dr. Chaoui said. "Whether you are employed or in a small practice, it means that patients walk through your door and trust you with their care."

### Your Two Cents

*Vital Signs* welcomes letters to the editor. Letters should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; [vitalsigns@mms.org](mailto:vitalsigns@mms.org); or fax to (781) 642-0976.

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## Patient Experience

continued from page 1

experience elements contained in the Medicare Accountable Care Organization program, Meaningful Use Stage 2, NCQA Patient-Centered Medical Home criteria, and other private accountable care delivery models, the scrutiny is quickly becoming more intense. Physician practices have an opportunity to make a good impression so that patients don't have to exercise their right of choice.

### What Is Patient Experience?

The term "Patient Experience" is defined by the Beryl Institute as "The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care." Over the years I've heard many stories that can be woven together to conceptualize the potential impact of the patient experience nicely:

A patient was treated by his primary care physician for an injury incurred while jogging. The PCP referred the patient to a specialist for a consult. The patient attempted to make an appointment but was told the wait time was four months — certainly not helpful given his current level of pain. The patient called the PCP for another recommendation and was successful in booking the appointment. The patient let the primary care office know the date and time of the appointment.

The patient arrived for his appointment at the specialist office and was greeted by an unfriendly receptionist who gave him a hassle about not having his information forwarded over in advance of his appointment. Apparently they had not received any information about why the patient was referred and a referral had also not been processed. The patient called the primary care office asking for the proper information to be sent over immediately. Once he was with the specialist in the exam room, he mentioned another compounding injury. The specialist told him he could only evaluate him for the one condition and that he would have to schedule another appointment



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for the second condition as he was extremely busy and didn't have time.

The patient noted that he really liked his PCP but was very unhappy with the lack of coordination. Unfortunately this was not the first time information was not handed off to a consulting physician. The patient also noted that he was unhappy that the specialist didn't have time for him given that he felt the two issues were related. The patient felt that he was not cared for in an appropriate manner and had hoped that his PCP would have referred him to someone who had time to treat him and also consider all of his concerns. He had taken time off from work and would now have to take more time off for the remainder of his concerns to be addressed. This patient had enough and ultimately decided to change primary care physicians and follow up with a different specialist.

### Impact of an Unhappy Patient

In this fictional story, the patient's experience resulted in a loss of business to both the primary care physician and the specialist. If surveyed, the patient certainly would have scored the experience in a less than favorable way. In a situation where metrics, pay-for-performance, or other payment incentives come into play, experiences like these would certainly impact the metrics and any associated incentive dollars. Regardless of incentive

plans, this patient changed practices ultimately resulting in a potential loss of revenue to the practice. Additionally, this patient clearly was willing to talk about his experience and that alone is enough to influence other patients in their decision to seek care with either of these practices.

What types of things can a practice do *immediately* to improve patient experience?

#### 1 Listen to your patients.

Encourage your staff to listen to the patients, they are your greatest source of information as to their experience and perspective of how well the system works and ease of transition across the care continuum.

#### 2 Look out for access issues.

Keep your ear to the ground and know what the wait time for appointments is with the physicians you refer to. Someone may be going on vacation and thus have a longer wait time for an appointment. That information is helpful to know.

**3 Proactively facilitate hand-offs.** Encourage your staff to be proactive in facilitating hand-offs. Make sure that the proper information is shared and the necessary steps are taken to ensure easy transition of the patient across the care continuum.

**4 Reflect internally.** Take a moment to consider the patient experience within your office, talk with your staff and work together to address process impediments and come up with a plan to provide the best possible patient experience locally.

The patient experience is clearly becoming a necessary focus in the business of medicine; however, it lends itself well to what physicians and their staff do best, providing great care for patients in an efficient manner.

Contact the Physician Practice Resource Center at [pprc@mms.org](mailto:pprc@mms.org) or (781) 434-7702 for more information on how to improve patient experience in your practice.



### Opt-in to Receive Vital Signs Online

Would you like to receive this monthly newsletter via email instead of U.S. mail?

Send an email to [vitalsigns@mms.org](mailto:vitalsigns@mms.org) with your preferred email as well as the address currently listed on your VS mailing label.

The MMS will begin emailing *Vital Signs* to you as a downloadable PDF in April.

## Law Expands Oral Health Services for MassHealth Patients

Beginning March 1, adult Medicaid patients will be able to see any MassHealth-participating dentist for fillings needed to restore their teeth, thanks to a recent law that reinstates some restorative services, which had been eliminated entirely in 2010. Existing benefits such as diagnostics, preventive, and oral surgery services continue to be available.

Physicians have been confused about where to send their patients for dental care and what services are covered, said Hugh Silk, M.D., a family physician and MMS Oral Health Committee Chair. "Physicians can once again send their adult patients to local dentists who accept MassHealth with confidence that their patients will receive the care they need."

"MassHealth has been working for years to improve access and at this point, there are approximately 2,300 dental providers participating with MassHealth equating to 95 percent of our members having access to at least two providers within five miles of their home," said Tracy Chase, executive director for MassHealth at Dentaquest, which administers the MassHealth dental program.

While restorative filling procedures for all teeth will now be fully

covered, certain services such as root canals, crowns, and dentures will still not be covered. MassHealth members can seek care for these services at a community health center dental clinic.

Employed adults lose more than 164 million hours of work each year due to oral health problems or dental visits. In the case of diabetics, pregnant women, and patients with heart disease, good oral health can potentially lower blood glucose levels, lower the risk for preterm labor, and decrease oral-systemic inflammation that leads to worsening heart disease, respectively.

Physicians see their patients routinely for preventive visits and periodically for chronic care; these are opportunities to make oral health screening and dental hygiene advice a part of your review of systems and health maintenance advice, said Dr. Silk.

"Make it easy for your office system and staff — have oral health handouts that include a list of local dentists who accept MassHealth."

To find a participating MassHealth dentist, visit [www.masshealth-dental.net](http://www.masshealth-dental.net) and click on "General Public," or call (800) 207-5019.

## RESOURCES >> Eliminating Health Care Disparities in Your Practice

BY ROBYN ALIE  
MMS PUBLIC HEALTH MANAGER

Health care disparities have significant economic consequences for the health care system, and in turn, for the business of medicine.

A 2009 Joint Center for Political and Economic Studies report found that such excess costs related to health care disparities were responsible for more than 30 percent — more than \$230 billion — of direct medical costs for African Americans, Hispanics, and Asian Americans from 2003 to 2006.

These excess costs result from the costlier care required to treat sicker people — patients who have not, for example, received preventive services such as recommended colorectal cancer screenings and other timely interventions.

A 2012 national health care disparities report found that while overall quality of health care in the United States is improving, health care disparities are not. The report found that blacks and Hispanics received worse care than non-Hispanic whites for 40 percent of quality measures; American Indians received worse care than whites for one-third of quality measures. And, Hispanics had the worse access to care compared to non-Hispanic whites for 70 percent of access measures;

American Indians for 40 percent; and blacks for one third of access measures compared to non-whites.

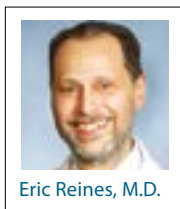
In Massachusetts, we have several years' experience with health care reform, and have seen most of our residents obtain insurance coverage. Yet, studies find that even among those with insurance, racial, ethnic, and socioeconomic disparities persist in both health care access and outcomes.

Because the Census Bureau estimates that in 30 years, half of the U.S. population will be minorities, finding ways to eliminate disparities through policy, systems, and practice changes will be critical to the long term viability of the health care system and its practices.

In cooperation with the Commission to End Health Care Disparities, the MMS will convene health care leaders from around the state and the nation at a Public Health Leadership Forum in April to discuss health care disparities, and examine the effects of health care reform on health care disparities as well as opportunities for further progress.

## When "Less Is More" for Your Patients

BY ERIC REINES, M.D.  
COMMITTEE ON GERIATRIC MEDICINE CHAIR



Eric Reines, M.D.

What should I do for my nursing home patient? She has become more fretful when meds are administered, and her appetite is off. She complains about all the pills.

Indeed, she takes pills for osteoporosis, hypertension, diabetes, hypercholesterolemia, G-E reflux, COPD, pain of osteoarthritis, constipation, depression, anxiety, and dementia.

Her family exhorts her to take the pills that have been prescribed

by her multiple specialists over the years. But does she really need all these pills? Will they enhance her quality of life, her ability to function independently, her longevity? Is there reliable evidence to help us decide, whether in textbooks, clinical studies, or guidelines?

We geriatricians, as well as physicians of all specialties, face similar dilemmas daily. Many of us are coming to the realization from experience that "less is more," and there is an emerging body of evidence to support this view. For instance, advanced lung cancer patients live longer with palliative care than with aggressive

cancer treatment. Elderly, multimorbidity diabetics fare better when HA1C goals are relaxed. The Joint National Committee has just relaxed blood pressure guidelines based on new evidence.

Acting as stewards of health care resources for all of society turns out to benefit our own individual patients as well. In the spirit of "Less Is More," the MMS has adopted policies calling on regulators and insurers to apply evidence appropriately when promulgating guidelines and pay-for-performance programs, and represents physicians at the State-wide Quality Advisory Committee.

The MMS Committee on Geriatric Medicine invites you to join us in learning how to get off the treadmill of testing and treating and start learning what matters most to our patients.

>> Read the series, "Less Is More," in *JAMA Internal Medicine*

>> Familiarize yourself with our own specialty's "Choosing Wisely" campaign at [www.choosingwisely.org](http://www.choosingwisely.org)

>> Advocate for wise policy and quality measurement at the SQAC and other agencies

## STATE UPDATE

## Mass. Requires Risk-Bearing Provider Organizations to Register

### Providers Must Determine if Waiver for 2014 Needed

BY WILLIAM RYDER, ESQ.  
MMS LEGISLATIVE COUNSEL

One of the contentious elements of Massachusetts's payment reform law, Chapter 224 of 2012, was the creation of risk-bearing provider organization, or RBPO, registration requirements. The law requires RBPOs to register with the Division of Insurance, with the Center for Health Information and Analysis, and with the Health Policy Council.

The rationale was that provider organizations, which take on significant risk, must fall under the DOI oversight before such RBPOs may take on alternative payment or risk-based contracts with insurers regulated by the division.

In the case of the HPC, the oversight authority is based on the council's desire for detailed information from providers on

services provided and costs. The MMS was active in the legislative arena to try to create exemptions for small groups which would allow them to compete for risk-based contracts. The statutory exemption is for those who do not take significant risk contracts and do not have a patient panel greater than 15,000 or represent providers who collectively receive \$25 million or more in annual net patient service revenue from carriers or third-party administrators.

These provisions apply to any provider organization that enters into contracts in which the payment methodology creates a downside risk. The DOI does not consider "service-based payments, including but not limited to, diagnostic-related group payments, 'per diems' or bundled payments, to constitute downside risk."

Under the initial exemption process, 79 organizations obtained transitional waivers from DOI certification in March 2013 while regulations were pending. These waivers allowed them to take on risk-based contracts with insurers. Initial rules required this only from parent organizations, which take on risk to register, and not from subcontractors within bargaining units.

This year, organizations will have to certify to the DOI that their contracts do not place their solvency at risk. Waivers may be obtained by organizations with no significant downside risk. Fee-for-service providers would not be affected. Providers will have to work with insurers for contracts renewing in 2014 to determine whether they need registration or waivers from the DOI.

The law allows the DOI to prohibit carriers from entering into or continuing an alternate payment contract with downside risk with a RBPO, unless the organization has obtained either a risk certificate or a risk certificate waiver. The initial onus is on carriers to comply with the law.

The law allows the HPC to require a fee from provider organizations upon registration, but this provision is waived for the first year. We anticipate further regulatory discussions in the spring of 2014.

Any questions regarding registration or waivers from DOI should be directed to Kevin P. Beagan, Deputy Commissioner of the Health Care Access Bureau, at (617) 521-7323 or [kevin.beagan@state.ma.us](mailto:kevin.beagan@state.ma.us).

## FEDERAL UPDATE

## Medicare — The Federal Financial Gorilla

BY ALEX CALCAGNO  
MMS DIRECTOR OF FEDERAL RELATIONS



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There is no federal funding program that has more impact on the viability of physician practices than Medicare. And as every

health policy analyst knows, with an aging population the role of Medicare becomes even more prominent. Did you know that 10,000 new Medicare enrollees enter the system every day? And that twice as many Medicare beneficiaries will enter the system in 2014 as in 2013?

But even this astonishing fact understates the reach of Medicare as a dominant payer in the U.S. health care market. In terms of covered lives, Medicare finances health care for Medicare beneficiaries, members of the military and their families (through Tricare), and persons with disabilities. In terms of its financial

clout, the impact of Medicare is further exacerbated by the fact that most private payers follow the Medicare fee schedule.

Yet for more than a decade, the Medicare physician fee schedule has grossly underestimated the real costs of providing care to Medicare beneficiaries. The ubiquitous SGR formula regularly underestimated the cost of care by a sizeable margin calling for double-digit cuts for many years. The impact of this uncertainty on the business of physician's practices has been undervalued in the policy arena. A group of prominent economists recently commented on what action, or intervention, would have the biggest impact on the U.S. economy. And the answer was not the much-heralded pronouncements of the Federal Reserve, but the recently passed Omnibus Appropriations Bill, which would keep the government funded until September 30, 2014. The reason the economists stated was that the spending bill gave the domestic markets some certainty as to federal spending — something the fall

government shutdown and Congressional budget failures had precluded.

If a nation of investors is worried about a stalled national budget, one can only imagine the impact of an annual 25 percent cut to a small medical practice; questions as to whether they can afford to invest in electronic medical records, hire staff, or invest in any of the new medical technologies necessary for up-to-date care of their patients. And while it is true that Congress has stopped the cut each year, there was never any guarantee that the cuts would not go into place.

And here is the other rub, if you will. In fact, physician's practices have been cut, because in order to stop the draconian cuts required by the SGR formula, there has been no increase in Medicare physician payment rates for well over a decade. To be exact, the cost of running a medical practice has risen by 25 percent nationally over the past 10 years, yet Medicare payments to physicians have clearly not increased at that rate.

This shortfall comes at exactly the time when the costs of running a medical practice are increasing dramatically — think labor, medical technology, costs of new regulation, inflation — coupled with, yes, an aging population.

As *Vital Signs* goes to press, Congress is working on legislation to eliminate the SGR permanently. The proposed new payment formula looks to include a revised form of fee-for-service with updates that will be based on how physicians meet certain quality and efficiency metrics in their practice/specialty. There would also be different payments for those who practice in medical homes, ACOs, and other alternative payment systems.

Whether the new system will give physicians more certainty is unclear, but if the new methodology is done correctly, physicians should have more control over their financial destiny in Medicare.

PHYSICIAN HEALTH MATTERS

## Welcome to Health Care Airways?

BY STEVE ADELMAN, M.D.  
PHS DIRECTOR

There are numerous parallels between the health care industry and the aviation industry. Dr. Atul Gawande makes a compelling case for the use of aviation-style safety checklists in health care in his bestseller, *The Checklist Manifesto: How to Get Things Right*. Passenger and patient lives are saved when complex processes are reviewed in a standardized and methodical fashion. Like airline pilots, doctors need to report to work in full command of their faculties; that's why stringent regulations prohibit public safety professionals from misusing alcohol and other psychoactive substances.

Translating the current state of health care into a series of aviation metaphors may help us to gain a fresh perspective on the transformation of our calling into the somewhat beleaguered profession that is at the heart of the largest sector of the U.S. economy. Here's what comes to mind when expressing our many doctoring dilemmas in the language of aviation:

Attending flight school has become prohibitively expensive. Because aviation technology is evolving rapidly and gaining

complexity, learning how to fly has never been more demanding and more time-consuming. Some pilots who trained years ago and gained mastery of the last generation of planes find themselves on a learning curve with the newer models. The industry, government, and society have responded to all these changes with a bevy of requirements and regulations. With all eyes watching, losing one's license to fly has never been easier.

When it comes to commercial aviation, pilots who operate their craft with independence and autonomy are a vestige of the past. Today's pilots are members of a larger and more varied crew. Although the pilot is accountable for what goes wrong on board and in flight, he or she is not always able to control the decisions and actions of one or another crew member. In the bygone era, that pilot's word was gospel; these days other members of the crew sometimes question or contradict the pilot. That never used to happen.

Even the passengers have changed. They and their families have more information at their fingertips and are not afraid to use it. Afraid of bumpy flights and the possibility of a bad

outcome, they utilize technology to bombard the cockpit with questions and comments about the pilot's operation of the aircraft. The volume of communication is sometimes overwhelming.

As technology has advanced and occupational complexity has proliferated, the industry has become less and less profitable and has even started to lose money. Squeezing more passengers onto every flight and more flights into the work week has become necessary, but, as they step up their efforts to keep pace, fewer and fewer pilots are experiencing the joys of flying.

At the same time, most pilots these days have spouses who work, so there is more to do on the home front than ever before. The increased demands at work and at home are such that some pilots have started cutting corners when it comes to taking good care of themselves. Ignoring one's well-being can lead to health problems that have the potential to end a career. Those who make it to the "finish line" are required to retire — in 2007, the FAA increased the mandatory retirement age from 60 to 65.

Unlike pilots, there is no mandatory retirement age for physicians. An estimated one-fifth of

the nation's physicians are over 65 years of age, and that proportion is expected to rise. Many are under increasing financial pressures that make them reluctant to retire.

I recently received an email from a distinguished middle-aged colleague in another state who wrote, "I am extremely burned out. I am actually considering retirement in the next year. I doubt that it would be permanent, but I would like to devote more time... to taking care of myself. My health has always been quite good, but stress, hypertension, weight gain, and arthritis are finally beginning to catch up with me."

Standardized checklists can help pilots and physicians to provide safe and effective service to the public. The medical profession, and the health care industry that depends on well-functioning physicians, need to envision and implement effective and standardized approaches that enhance the well-being and professional vitality of doctors. Those of us charged with caring for others should be caring for ourselves in exemplary fashion, and the current state of "the business of medicine" has made it more difficult than ever to do so.

RESOURCES >>

To help foster development of our younger colleagues, the MMS provides relevant and timely resources designed to guide early career physicians along a path towards professional success and fulfillment.

A few of the resources the MMS has designed to help Young Physicians include:

>> Asset Protection, Allocation, and Security training to build foundational financial planning skills

>> Employment contract anatomy, negotiation strategies for salary and benefits, and important insurance considerations

>> Education on communication, apology, and resolution as alternative approaches to traditional medical liability

>> Immigration and Visa requirements and considerations for International Medical Graduates

>> Leadership and Legislative advocacy training through involvement in MMS Committee activities

>> March 29, 2014, Professional Development Workshop [www.massmed.org/careerworkshop](http://www.massmed.org/careerworkshop)

Young Physician members are invited to participate in the MMS Committee on Young Physicians to understand the MMS gover-

nance structure and actively participate in legislative and regulatory policymaking.

For more information, contact Colleen Hennessey at [chennessy@mms.org](mailto:chennessy@mms.org) or (781) 434-7315.

## The Business of Being a Young Physician



Photo by Colleen Hennessey

Glenn L. Noland, financial Advisor, Baystate Wealth Management and New England Securities presents at the recent MMS-hosted program "Managing Student Debt & Building Wealth."

RESOURCES >>

The MMS is dedicated to helping physicians run their practices by offering access to exclusive or discounted benefits and services as part of their membership.

**Credit Card Processing Services.** Webster Bank Merchant Services, working with First Data, offers a comprehensive suite of electronic payment solutions. Explore their \$500 Meet-or-Bear offer. **Visit:** [www.websterbankmerchant.com/mms](http://www.websterbankmerchant.com/mms)  
**Phone:** (800) 298-4266

**Secure Mobile Messaging from DocbookMD®.** A free benefit available only to MMS members, it provides a secure messaging application for mobile devices, allowing you to collaborate with other MMS colleagues. **Visit:** [www.massmed.org/docbookmd](http://www.massmed.org/docbookmd)  
**Email:** [docbookmd@mms.org](mailto:docbookmd@mms.org)

**Collection Services from I.C. System.** Provides effective solutions for collecting debts and improving cash flow without jeopardizing patient relationships. MMS members enjoy members-only discounted pricing. **Visit:** [www.icmemberbenefits.com](http://www.icmemberbenefits.com)  
**Phone:** (800) 279-3511

**Data Storage and Backup from Vaultlogix.** Vaultlogix understands that your business depends on your data and provides online backup and recovery services that exceed government data security requirements. Exclusive discounts are available to MMS members. **Visit:** [www.massmed.org/vaultlogix](http://www.massmed.org/vaultlogix)  
**Email:** [sales@vaultlogix](mailto:sales@vaultlogix)

**Review EHR Ratings Through KLAS Research.** The MMS has partnered with KLAS Research to bring to MMS members the most impartial and useful information to help them make informed decisions

regarding the implementation of electronic health records systems. **Visit:** [www.massmed.org/ehr/klas](http://www.massmed.org/ehr/klas)

**Individual Claims Consultations.** Annually, the MMS Regional Offices organize free problem-solving work sessions to assist members with adjudicating troublesome claims. **Contact your local regional office at** [www.massmed.org/districts](http://www.massmed.org/districts).

**Practice Management Solutions from athenahealth, Inc.** A provider of cloud-based services for electronic health records, practice management, patient communication, and care coordination. Discounts available to MMS members. **Visit:** [www.athenahealth.com/mms](http://www.athenahealth.com/mms)  
**Phone:** (888) 402-6942

**Legal Advisory Plan.** A prepaid legal service — available only to MMS members — provides legal advisory and consultation services for specified Board of Registration in Medicine matters. **Visit:** [www.massmed.org/lap](http://www.massmed.org/lap)

IN MEMORIAM

The following deaths of MMS members were recently reported to the Society. We also note member deaths on the MMS website, at [www.massmed.org/memoriam](http://www.massmed.org/memoriam).

**F. Knight Alexander, M.D.,** 78; Marblehead, MA; Hahnemann Medical College and Hospital, 1964; died February 14, 2013.

**Americo B. Almeida, M.D.,** 87; Fall River, MA; University of Vermont College of Medicine, 1959; died August 29, 2013.

**Bryant Barnard, M.D.,** 76; Wenham, MA; Cornell University Medical College, 1962; died August 17, 2013.

**Putnam P. Breed, M.D.,** 75; Newburyport, MA; Boston University School of Medicine, 1964; died September 18, 2013.

**Colin E. Forsyth, M.D.,** 56; Yarmouth Port, MA; New Jersey Medical School, 1981; died March 15, 2013.

**Collingwood S. Karmody, M.D.,** 84; Hilton Head Island, SC; National University of Ireland, 1955; died November 15, 2013.

**Francis E. Kasuba, M.D.,** 88; Milton, MA; Tufts University School of Medicine, 1954; died April 30, 2013.

**John P. Latchlaw, M.D.,** 61; Milton, MA; Temple University School of Medicine, 1978; died September 20, 2013.

**William L. McCarthy, M.D.,** 85; Hingham, MA; Boston University School of Medicine, 1954; died December 2, 2012.

**Robert S. Marnoy, M.D.,** 85; Houston, TX; Boston University School of Medicine, 1954; died February 18, 2013.

**Frederick L. Mazer, M.D.,** 74; Lexington, MA; Harvard Medical School, 1964; died April 1, 2013.

**W. Bradford Patterson, M.D.,** 92; Shelburne, VT; Harvard Medical School, 1950; died April 10, 2013.

**Liselotte E. Sigmar, M.D.,** 82; Dallas, TX; University of Vienna, Austria, 1957; died February 23, 2013.

**Michael V. Sobel, M.D.,** 76; Cambridge, MA; Albert Einstein College of Medicine, 1961; died July 4, 2011.

**Malcom C. Veidenheimer, M.D.,** 84; Burlington, MA; Queen's University Faculty of Medicine, Kingston, 1954; died July 30, 2013.

**Lewis R. Weintraub, M.D.,** 79; Dedham, MA; Harvard Medical School, 1958; died August 18, 2013.

**John J. White, Jr., M.D.,** 75; South Chatham, MA; Columbia University College of Physicians and Surgeons, 1962; died January 17, 2012.

ACROSS THE COMMONWEALTH

District News and Events

NORTHEAST REGION

**Charles River — Executive Committee Meeting.** Tues., March 25, 5:30 p.m. Delegates meeting immediately following at 6:30 p.m. Location: MMS headquarters, Waltham.

**Essex South — Delegates Meeting.** Wed., March 26, 6:00 p.m. Location: Beverly Depot Restaurant, Beverly.

**Middlesex — Executive Committee Meeting.** Wed., March 12, Location: Capital Grille, Burlington.

**Middlesex Central — Executive Committee Meeting.** Thurs., March 20, 7:45 a.m. Location: Emerson Hospital, Concord.

For more information on these events, or if you have Northeast District news to contribute, please contact Michele Jus-saume or Linda Howard, Northeast Regional Office at (800) 944-5562 or [mjussaume@mms.org](mailto:mjussaume@mms.org) or [lhoward@mms.org](mailto:lhoward@mms.org).

SOUTHEAST REGION

**Bristol North and Plymouth — Joint Spring Meeting.** Tues., April 1, 6:00 p.m. Location: Boston Tavern, Middleboro.

**Norfolk South — Spring Annual Meeting.** Tues., March 18, 6:00 p.m. Location: Neighborhood Club of Quincy, Quincy. Guest Speaker: Keith Lewis, M.D.

For more information, or if you have Southeast District news to contribute, please contact Sheila Kozlowski, Southeast Regional Office at (800) 322-3301 or [skozlowski@mms.org](mailto:skozlowski@mms.org).

WEST CENTRAL REGION

**Berkshire — Annual District Meeting.** Thurs., March 13, 6:00 p.m. Location: Country Club of Pittsfield. Speaker: Dr. Ronald Dunlap, MMS President. Topic: Getting Ready: What Physicians Need to Know about ACOs and the New Practice Environment. **High School Doctor for a Day Program.** Wed., March 19, 7:30 a.m. to 4:00 p.m. Location: Berkshire Medical Center, Pittsfield.

**Hampden — Legislative Breakfast.** Fri., March 28, 7:00 to 9:00 a.m. Location: The Yankee Pedlar Restaurant, Holyoke. **High School Doctor for a Day Program.** Wed., April 16, 7:00 a.m. Breakfast, 5:00 p.m. Debriefing. Location: Baystate Conference Center, Holyoke. For more information, contact Hampden District Office at (413) 736-0661 or [hdms@massmed.org](mailto:hdms@massmed.org).

**Worcester — Women in Medicine Leadership Forum.** Wed., March 12, 5:30 p.m. Location: Beechwood Hotel. Topic: Domestic Violence and Intervention in Our Community. Speakers: Ginger Navickas, former executive director, YWCA Day-break, Worcester. **A Night at the Movies.** "A Place at the Table." Wed., March 19, 5:30 p.m. Location: Mechanics Hall, Worcester. For more information, contact Joyce Cariglia at (508) 753-1579 or [wdms@massmed.org](mailto:wdms@massmed.org).

For more information, or if you have West Central news to contribute, please contact Cathy Salas, West Central Regional Office at (800) 522-3112 or [csalas@mms.org](mailto:csalas@mms.org).

## The Business of Being a Physician



### IN THIS ISSUE

- 1 > Success in the New Practice Environment
  - > Find Your EHR Adoption Sweet Spot
  - > Patient Experience: The Metric You Can't Ignore
- 2 > President's Message: Our Business as Physicians
- 3 > Opt-in to Receive *Vital Signs* Electronically
- 4 > Eliminating Health Care Disparities
  - > Deciding if "Less Is More" For Your Patient
- 5 > New Rules for Risk-Bearing Provider Organizations
  - > Medicare — The Financial Gorilla
- 6 > Welcome to Health Care Airways?
  - > The Business of Being a Young Physician
- 7 > Across the Commonwealth
  - > In Memoriam



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# VITALSIGNS

VOLUME 19, ISSUE 3, MARCH 2014

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## MMS SPONSORED AND JOINTLY SPONSORED CME ACTIVITIES

### LIVE CME ACTIVITIES

Go to [www.massmed.org/calendar](http://www.massmed.org/calendar). Unless otherwise noted, event location is MMS headquarters, Waltham.

#### Managing Workplace Conflict

Thurs., March 13, 2014, 8:00 a.m. to 4:00 p.m. and Fri., March 14, 2014, 8:00 a.m. to 3:00 p.m.

#### 12th Annual Symposium on Men's Health

Wed., June 11, 2014, 8 a.m. to 5:00 p.m.

#### SAVE THE DATE

#### 2014 Massachusetts Medical Society and Rhode Island Medical Society Directors of Medical Education Conference

Thurs., May 1, 2014

### ONLINE CME ACTIVITIES

Go to [www.massmed.org/cme](http://www.massmed.org/cme).

#### Risk Management CME

##### End-of-Life Care

- Principles of Palliative Care and Persistent Pain Management (6 modules)
- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- *Legal Advisor*: Advance Directives

##### Pain Management

- Opioid Prescribing, Risk Management of Opioid Therapy and the Opioid Abuse Epidemic (6 Modules)
- *Legal Advisor*: Identifying Potential Drug Dependence and Preventing Abuse
- Managing Risk when Prescribing Narcotic Painkillers for Patients

#### Other Risk Management CME

- Preventing Falls in Older Patients: A Provider Toolkit
- Guide to Accountable Care Organizations: What Physicians Need to Know
- HIPAA 2.0: What's New in the New Rules?
- Cancer Screening Guidelines (3 modules)
- Impact of Effective Communication on Patients, Colleagues, and Metrics (2 modules)
- Effective Chart Review for Quality Improvement

#### Other CME

- Contracting with an ACO
- Finance 101 for Physicians and Practice Administrators
- A Roadmap to Bring an End to HIV and STDs in Massachusetts: (3 modules)
- Using Data Wisely
- Just a Spoonful of Medicine Helps the Sugar Go Down: Improve Management of Type 2 Diabetes
- Weighing the Evidence on Obesity
- Aggregating the Evidence on Antiplatelet Drugs: A Review of Recent Clinical Trials
- Acid Suppression Therapy: Neutralizing the Hype



TO REGISTER FOR ANY OF THESE ACTIVITIES, CALL (800) 843-6356.

CME CREDIT: These activities have been approved for *AMA PRA Category 1 Credit™*. For additional information, contact the Department of Continuing Education and Certification at (800) 322-2303, ext. 7306, or go to [www.massmed.org/cmecenter](http://www.massmed.org/cmecenter).