

# VITAL SIGNS



MASSACHUSETTS  
MEDICAL SOCIETY

*Every physician matters,  
each patient counts.*

VOLUME 20, ISSUE 5, MAY 2015



## Final Meaningful Use Rules

BY LEON BARZIN  
MMS HIT DIRECTOR

For those who have struggled with Meaningful Use, the most welcome 12 words among the 301 pages of the just-released *Notice of Public Rule Making for Stage 3* may be these: “Stage 3 of Meaningful Use is expected to be the final stage.”

Since its inception in 2009, more than \$25 billion has been distributed in an effort to persuade providers to digitize medical records. The carrot-and-stick nature of the program did succeed in increasing the use of

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## Medicare Payment Formula Repealed

### Congress Approves Landmark Bill

BY ALEX CALCAGNO  
MMS DIRECTOR OF COMMUNITY AND  
FEDERAL RELATIONS

Congress has approved legislation repealing the flawed Medicare payment formula that has plagued physicians for more than 17 years.

The Sustainable Growth Rate, or SGR, was an element of the Medicare physician payment formula that tied annual changes in payment rates to fluctuations in various economic benchmarks. The formula inaccurately compensated physicians for the cost of medical practice, and it has

destabilized the finances of the Medicare program.

The SGR repeal legislation passed the House and Senate by overwhelming majorities in April.

*“Your voices were heard.”*

— Richard Pieters, M.D.  
MMS President

The approval came just hours before yet another payment patch was set to expire and Medicare would have been forced to cut physician payments by 21 percent for all services provided after March 31.

In the weeks leading to the vote, thousands of physicians from around the country — including several hundred from Massachusetts — participated in an email campaign urging Congressional lawmakers in both chambers to pass the bill.

The new legislation guarantees physicians a 0.5 percent rate increase every year through 2019, when a series of quality incentive payments become available. The first 0.5 percent increase takes effect July 1, 2015, followed by another on Jan. 1, 2016.

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## Apps For Physicians and Patients: The Next Frontier for EHRs?

### May 7 Conference Focuses on Innovations and Implications

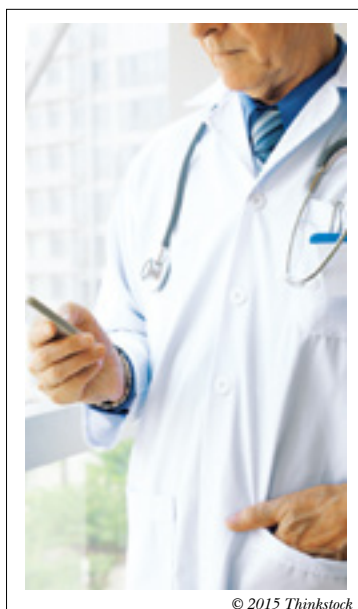
BY VICKI RITTERBAND  
VITAL SIGNS STAFF WRITER

Many doctors dislike their electronic health record systems. They’re anything but intuitive, inputting data can be clunky, and users are locked into a certain way of doing and viewing things. And forget about interoperability: each is an island unto itself.

Until recently, EHR vendors have had few financial incentives to allow the development of third-party apps. “If vendors can keep people locked into their system, then they can control the customer. It’s very limiting to the care patients can receive,” said internist Glen Tucker, M.D., medical director of information systems at Sturdy Memorial Hospital and chair of the MMS Committee on Information Technology.

But a pair of technological innovations hold the promise of both dramatically improving the way these much-maligned tools

work and involving patients more in their own care. Ricky Bloomfield, M.D., an internist and pediatrician as well as director of mobile technology strategy at Duke Medicine, works at the intersection of these twin efforts



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to transform the EHR into an easily customizable tool and enable it to leverage one of the hottest trends in consumer technology: wearable health tracking devices. Today, the global size of the market for these self-monitoring devices is estimated at \$2 billion. That number is expected to grow to \$41 billion by 2020, according to Soreon Research.

#### Apps Invade Health Care

Dr. Bloomfield and three other nationally renowned panelists will discuss these and other health IT innovations at the Massachusetts Medical Society’s May 7 conference, *Apps Invade Health Care: Why You Should Care*. The event will take place at the Harvard Martin Conference Center and is open to members and non-members.

What might the future look like if these efforts succeed? A cardiologist could buy and plug

into his or her EHR — no matter what the brand — a new Reynolds Risk Score application, chosen from a menu of 20 competitors listed in an EHR app store. Blood pressure data from a patient’s watch-like monitor would flow smoothly into any EHR, enabling his internist to make intelligent medication adjustment decisions with a couple of mouse clicks.

Duke Medicine is taking its first steps towards this possible future. In late 2014, it became one of two hospitals in the country to integrate Apple’s HealthKit mobile platform with its Epic EHR, enabling a small pilot of patients with congestive heart failure to monitor values such as blood pressure, weight, and activity at home with Duke-provided devices. The data is then transmitted directly into their physicians’ EHRs. The assumption is that the data will allow physicians to make better

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## PRESIDENT'S MESSAGE



### Looking Back, Looking Forward

As my presidency draws to a close, I wanted to reflect on the eventful year we have shared together.

In my first President's Message for *Vital Signs*, I wrote that health care reform seemed to bring physicians an endless series of challenges, but that the doctor-patient relationship must remain central to everything we do.

We did our best to keep this in perspective as we advocated for reforms to the state's prescription monitoring program to allow us to treat pain and balance opioid safety, asked the Massachusetts Legislature to create physician-led health care teams that give patients the most highly qualified providers, and helped champion historical Medicare reform in the halls of Congress.

One of my priorities this year has been to advocate for the value of our medical professionalism. This is not only the essence of our calling as physicians, but our best defense as we face new challenges. I feel even more strongly that the best way to achieve high quality health care is for physicians to promote a culture of commitment to lifelong learning, robust interphysician communication, duty to patients, honor, and respect. I hope the MMS will build on these pillars for many years to come.

As I prepare to leave this post, I want to extend my deepest thanks to all of the physicians who work so hard and volunteer their time to this medical society. It has truly been an honor serving as your president. Thank you.

— Richard S. Pieters, M.D.

### Apps For Physicians and Patients

*continued from page 1*

care decisions earlier, while empowering patients to participate more fully in their care, according to Dr. Bloomfield. But he is cautious about predicting how transformative these data streams will be.

"When it comes to increasing the scale and scope of receiving patient-generated data, we don't know what we don't know," admitted Dr. Bloomfield, who said that Duke's pilot doesn't yet have any notable results to report. "Intuitively, we all feel that yes, we will find something here. If you have lots of quality data, you will find things. That's the history of science. But until we start finding patterns in the data, we won't know what the benefit will be."

Dr. Bloomfield is confident, however, that in the future these monitoring devices will be woven — quite literally — into the fabric of our lives. "Eventually they will be a seamless part of not just our watches and glasses, but our clothes, our underwear, even our bodies — removing their intentional use and making it automatic," he said.

### Physician Concerns

Dr. Tucker points out that turning on the data spigot needs to be done thoughtfully to prevent a physician's worst nightmare. "Most practicing physicians worry that it will be a deluge of information that is not helpful, hard to interpret and very time-consuming to look at," he said. "But we hear that same concern every time we make changes to our electronic communication with patients. Many of those concerns never came to pass. There will be growing pains, but we will figure it out."

He added that physicians are also concerned about reimbursement for interpreting and acting on all this new data, but that the move to value-based payment may make this less of an issue.

In the Duke pilot, physicians decide when to turn the data stream on, how often they want to be notified when data comes in, and what values will trigger an alert.

"A provider can say, 'I don't want any notifications, but I would like the information to be available the next time the patient comes into the clinic,' or 'I want to know about it every day so my nurse manager can flag it if something is out of whack and we need to intervene sooner,'" explained Dr. Bloomfield. "These are all things that will be worked out clinic by clinic, provider by provider. We don't want to dictate how the data is used."

*Apps Invade Health Care* panelist Adrian Gropper, M.D., the chief technology officer of Patient Privacy Rights, will bring to the table a cautionary message about the need for autonomy and transparency as health care apps become more prominent in the patient-caregiver relationship. Dr. Gropper will argue that apps should link patients directly to their physicians — without intermediaries like hospitals and integrated delivery networks. He also believes that physicians should choose only apps that are open-source — that their source code is available to anyone. "What's the difference between prescribing an app with 'secret' software to prescribing an medication with a secret ingredient?" he asked.

### A Future EHR App Store

Duke's other EHR innovation is its implementation of the so-called SMART on FHIR platform.

SMART, which was developed at Harvard Medical School and Boston Children's Hospital, stands for Substitutable Medical Apps and Reusable Technologies. FHIR is the acronym for Fast Healthcare Interoperability Resources. (Program panelist Kenneth Mandl, M.D., co-leads the SMART Platforms Initiative.)

The platform has begun enabling Duke to more easily customize its Epic system with apps that perform specific tasks — for example, SMART's open source Pediatric Growth Chart, with functionality that includes an easy-to-understand, graphically rich interface for parents. All of the major EHR vendors have endorsed FHIR — the standards framework at the heart of the platform — which should inspire lots of application innovation and dramatically improve EHR functionality in the near future, say supporters. "The value of this is that you can write a SMART app once, not know which EHR the end users has and know it will work — just like you can download any iPhone app, and know it will work," he said. The goal is to eventually have the same dizzying array of applications for EHRs that now exist for cell phones and other mobile devices.

Dr. Tucker admitted that he doesn't know a lot about the SMART platform, but he is less sanguine about EHR vendors giving up potential revenue to enable third-party innovation. "That's what the May 7 event is all about," said Dr. Tucker. "We want to get physicians, developers, policymakers and others into one room to talk about these issues."

Register for the May 7 conference at [www.massmed.org/apps2015](http://www.massmed.org/apps2015).

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# Patient Experience: The Importance of Staff Performance Appraisals

BY JILLIAN PEDROTTY  
PPRC SPECIALIST

In a world where patient experience metrics continue to gain increasing importance, it is no secret that staff satisfaction and job competencies may often influence patient care. Implementing a process to measure staff performance and hold individuals accountable to delivering great service is extremely important. In today's health care environment, staff performance appraisals are a vital tool in the creating a culture of continuous improvement.

Documented staff performance appraisals and evaluations should take place annually and include a review and discussion of performance, based on results and facts, not opinions, which help the manager determine the staff member's performance gaps and successes. Once gaps are identified and communicated to the employee, steps to improve performance can be taken and a timeline for follow-up and review can be established.

There are five key components that an evaluator may consider in

establishing a successful, formal performance appraisal process:

**1 Defining the requirements of the job** Typically, this includes the job title, brief summary of the job, and specific duties. Additionally, qualifications, experience, education, and skills needed for job related tasks are included. The job requirements should be shared with the employee during the hiring process so that the staff member understands the expectations of the role.

**2 Establishing standards of performance** When considering metrics for performance, the standards should be specific, measurable, attainable, realistic, and timely. A rating system — such as exceeds, meets, fails to meet expectations — can be used to maintain consistency across practice staff and minimize personal opinions that may affect the review.

**3 Monitoring performance** Managers should continuously be observing staff performance and demeanor between appraisals.

Mid-year reviews or other defined check points may help in working with staff on improving performance over time.

**4 Writing the performance appraisal** Organizations should consider using a standard form to capture and deliver consistent information across the organization. Adjustments may be necessary to capture the expectations for different staff types (i.e., clinical vs. administrative support). Some considerations include, focusing on the entire review period and objective behavior, supporting the evaluation with specific examples of employee behavior, using words that are measurable assessments of employees' strengths and weakness, and setting goals for improvement that can be objectively measured.

**5 Conducting the performance appraisal meeting** Being prepared is paramount for success. Reaffirming employee strengths and addressing areas for additional education or improvement can help in setting a

positive tone. Ideally, the meeting serves as a two-way conversation, so the employee can voice comments and concerns and a plan for any necessary improvements can be agreed upon by both parties. The employee appraisal process should include recognizing the individuals' training and development needs, genuine employee recognition, linking organizational and personal/professional goals and objectives, improving productivity and efficiency, and providing written documentation.

For more information visit [www.massmed.org/pprc](http://www.massmed.org/pprc).

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## Five Months Until ICD-10 Implementation: Adjusting Encounter Forms and Superbills

BY KERRY ANN HAYON  
DIRECTOR, PRACTICE SOLUTIONS AND  
POLICY RESEARCH

*This is the third in a series of Vital Signs articles intended to assist members in preparing their practices for the changes ICD-10 implementation will bring.*

The implementation date for ICD-10, October 1, 2015, is rapidly approaching. We often get questions from practices about how to adjust their processes, and adjusting encounter forms and superbills is one specific concern that is often raised.

In general, most practices have fine-tuned their forms, electronically or on paper, to maximize efficiency. All of the key services and procedures are outlined so that physicians can easily select what services they have provided for a patient and the associated diagnosis codes. I often hear things like, "it is going to take five pages to convert my current form onto an ICD-10 optimized form."

My general response to this is to know your data and consider the following key steps:

**Know Your Data** Conduct a quick analysis to determine the top 10 to 20 ICD-9 codes used by your practice and what percent of your total volume these codes represent. If any of these codes represent a small percentage of the volume, then elimination of these codes on the encounter form or superbill may be a reasonable idea.

**Map Top Codes** Take the top codes you've identified and correlate them to the associated ICD-10 codes. In some cases, it may be a one-to-one match, in other cases it may be a one-to-multiple match. This may be one factor in helping you streamline what really needs to be on the ICD-10-optimized form. If a "not necessary, but nice to have" code results in a one-to-multiple mapping and uses a

### Quick Hit ICD-10 Checklist

- Speak with Vendors
- Educate Your Staff
- Conduct a Documentation Gap Analysis
- Review Internal Processes
- Create Your ICD-10 Conversion Plan
- Develop a Test Plan
- Create a Plan for Post Go-Live Monitoring



in which the codes are used, you can evaluate which codes are truly necessary for the bulk of your work.

Most practices are able to refine their lists to the essentials and create a form (electronic or paper-based) that makes sense for their daily processes.

Be sure to allocate time and resources to this process in advance of the October deadline. Additionally,

lot of real estate, consider eliminating it on the updated form.

**Determine True Necessity** Once you have correlated the codes and understand the volume of patients the codes apply to, as well as the frequency

allocating extra time for input from physicians and other practice staff will ultimately ensure easier adoption of the new forms and a smoother operational transition. For additional information, please visit [www.massmed.org/icd10](http://www.massmed.org/icd10).

## MMS Men's Health Conference to Feature National Men's Health Leader

BY ROBYN ALIE  
MMS PUBLIC HEALTH MANAGER



Culley Carson III, M.D.

Culley Carson III, M.D., a national leader in Men's Health, will open the 13th Annual Men's Health Symposium on June 18. MMS will honor Dr. Carson with its Men's Health Award.

"We're so pleased to recognize Culley Carson for his incredible contribution to men's health, and that he will share his expertise with us at the Men's Health Symposium," said Bruce Campbell, M.D., chair of MMS's Committee on Men's Health.

Dr. Carson is the Rhodes Distinguished Professor in the department of urology at the University of North Carolina, Chapel Hill. Carson specializes in men's health, including erectile dysfunction and Peyronie's disease. Dr. Carson has consistently been recognized by his peers as among the Best Doctors in America in Urology.

Dr. Carson is the president of the American Society for Men's Health and the congress president for the International Society of Men's Health. He is editor-in-chief of *Sexual Medicine Reviews* and associate editor for the *Journal of Men's Health* and the *Trends in Urology* and *Men's Health Journal*. Dr. Carson has published

more than 200 peer-reviewed articles and edited several textbooks.

Dr. Carson received his medical degree from the George Washington University School of Medicine, and completed residencies in general surgery at the Dartmouth Hitchcock Medical Center and urology at the Mayo Clinic, and served as a flight surgeon in the United States Air Force.

The June 18 symposium aims to help clinicians better understand and treat their male patients.

### 13th Annual Symposium on Men's Health

JUNE 18, 2015  
7:30 A.M.-4:30 P.M.  
MMS HEADQUARTERS, WALTHAM

Learn from experts on hot topics in men's health:

- Comfortably Numb: Addiction, Medical Marijuana, and Chronic Pain
- Prostate Cancer Screening
- Intimate Partner/Domestic Violence — the Male Perspective
- Sports Medicine and Sports-Related Injuries
- Sleep Apnea
- And more!

More information and registration at

[www.massmed.org/mh2015agenda](http://www.massmed.org/mh2015agenda).

### Meaningful Use

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electronic health/medical records from single digits to upwards of 80 percent nationwide.

During the heyday of Stage 1, more than 800 EHR companies vied for federal incentives as technology vendors and providers struggled with new demands of "checkbox-like" requirements, technical training of staff, and extensive reports.

Stage 2, launched in 2014, piled on additional requirements and challenged vendors with increased re-certification demands and practices with more rigorous reporting.

With this background, the announcement of Stage 3 was understandably anticipated with trepidation. Fortunately, this recent notice appears to be relatively modest in additional requirements to practices. Interoperability and patient engagement appear to be the main priorities.

Key elements include the following:

- Electronic prescribing thresholds will increase to 80 percent for eligible providers and 25 percent for eligible hospitals. Controlled substance prescriptions can now be optionally included in states, such as Massachusetts, where it is allowed electronically.
- Physician order entry will be computerized on at least 80 percent of medication orders, 60 percent of lab orders, and 60 percent of diagnostic imaging orders.
- More than 80 percent of patients must be able to access their records and 35 percent of patients must have access to patient-specific educational resources.
- At least 25 percent of patients must access their records, and 35 percent of them must receive a clinically relevant secure message.

## Older Driver Safety Summit

Planning a Safe and Mobile Future for Massachusetts

Join key thought leaders as we discuss research, practice, policy, and innovations in older driver safety.

**June 16, 2015**

**7 a.m. to 4:30 p.m.**

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- **Medical Track:** Driver Fitness — How to Assess, Counsel, and Report At-Risk Drivers
- **Policy Track:** Legislation and Policies Impacting Older Drivers
- **Mobility Track:** Keeping Older Adults Moving, Safe, and Engaged after They Stop Driving
- **Infrastructure Track:** Roadway and Vehicle Improvements to Assist Older Drivers

**Registration Fee — \$75 (Student/Retiree: \$35)**

Hosted by the Gerontology Institute and the McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston

**For More Information and To Register:**  
<http://scholarworks.umb.edu/olderdriverssafetysummit>

### Reality Medicine 2015



Photo by Jill Cricones

Past MMS presidents Alice Coombs, M.D., (left) and Ronald Dunlap, M.D., (right) listen to panelist Christine David, M.D., at the MMS Reality Medicine program on March 25. See page 7 for more from the event.

STATE UPDATE

# MMS Advocates for Improved Decision Making for Incapacitated Patients

BY BRENDAN ABEL, ESQ.  
LEGISLATIVE AND REGULATORY AFFAIRS  
ASSISTANT COUNSEL

The MMS is pleased to have introduced a new bill in the state house this January, *An Act Improving Medical Decision Making*, aimed at improving the surrogate decision-making process for incapacitated patients. The bill is sponsored by Rep. Christopher Markey and Sen. Thomas Kennedy.

Patients have long had a fundamental right to make decisions relating to their medical treatment; this right survives a patient's loss of decisional capacity. Various state and federal laws thus provide important mechanisms for surrogate medical decision making on behalf of incapacitated patients.

In Massachusetts, the gold standard is the health care proxy, which provides a proxy with full medical

decision-making authority for a patient should they lose capacity, subject to some important patient protections.

Currently, providers treating patients without health care proxies are often required to seek judicial appointment of a medical guardian for care decisions for incapacitated patients, and they must return to the courts for additional sign-off on certain subsequent decisions such as transfers to nursing homes. This MMS bill would seek to improve medical decision-making processes for incapacitated patients by creating guidelines whereby their attending physicians could authorize surrogate decision makers for non-extraordinary medical decisions. Such reforms would maintain patient protections while also ensuring that surrogate decision makers can be appointed efficiently and consistently so as to minimize

delay in medical decisions and to reduce unnecessary burdens to patients' families and caregivers.

Importantly, the MMS bill does not interfere with the existing tools to facilitate surrogate decision making: a valid health care proxy or MOLST (Massachusetts Medical Orders for Life Sustaining Treatment) form take precedence over this process. However, for incapacitated patients lacking such advanced directives, judicial appointment of medical guardians would no longer always be necessary. Instead, the law allows the attending physician to appoint a surrogate decision maker — following a hierarchy list of possible surrogates — who would then be authorized to make decisions for the incapacitated patient. The surrogate would not have authority to make extraordinary medical decisions subject to heightened "substituted

judgment" standards in Massachusetts law.

The legislation provides for many patient protections once a surrogate decision maker has been appointed. Guidelines are provided to ensure that surrogates' decisions conform as closely as possible to the patient's wishes. Just as in the case of health care proxies or medical guardians, surrogate decision makers are required to take into account the patient's personal, philosophical, religious and moral beliefs, and ethical values, to the best of their ability, in making surrogate decisions.

The bill has been assigned to the Joint Committee on Children, Families, and Persons with Disabilities. MMS plans to testify in support of the bill this spring.

SGR

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MMS President Richard Pieters, M.D., called the repeal agreement "critical" to re-establishing a stable practice environment for physicians and more than one million Massachusetts seniors who depend on Medicare.

"We thank all the members of the Massachusetts Congressional Delegation who not only voted in favor of the bill, but remained committed over the years to reforming the Medicare payment schedule on behalf of the nation's seniors, military families, and persons with disabilities," said Dr. Pieters. "We are equally grateful to the leadership and members on both sides of the aisle that made passage of this landmark law a reality."

"We also thank the physicians who reached out and contacted their representatives in Congress," Dr. Pieters said. "Your voices were heard."

Read more about the history of the Medicare payment formula and the vote to repeal it at [www.massmed.org/medicare](http://www.massmed.org/medicare).

## Medicare Access and CHIP Reauthorization Act of 2015

	Current Law	SGR & Physician Payment
<b>Annual Medicare Update for Physician Services</b>	<ul style="list-style-type: none"> <li>• -21.2% SGR cut takes effect April 1, 2015.</li> <li>• Future SGR cuts could exceed 25%.</li> </ul>	Annual Update of: <ul style="list-style-type: none"> <li>• 0% January through June 2015</li> <li>• 0.5% July 2015 through 2019</li> <li>• 0% in 2020 through 2025</li> <li>• 2026 &amp; beyond: 0.75% for APM participants; 0.25% for all others.</li> </ul>
<b>Pay for Performance/Quality Reporting Programs</b>	<b>PQRS + MU + VBM Maximum Total Penalties</b> <ul style="list-style-type: none"> <li>• 2015: 4.5%</li> <li>• 2016: 6%</li> <li>• 2017: 9%</li> <li>• 2018: 10% or more</li> <li>• 2019: 11% or more</li> <li>• 2020: 11% or more</li> </ul> <b>PQRS:</b> Physician Quality Reporting System <b>MU:</b> EHR Incentive Program/Meaningful Use <b>VBM:</b> Value-Based Payment Modifier	<b>Merit-based Incentive Payment System (MIPS) Maximum Penalties &amp; Bonuses</b> <ul style="list-style-type: none"> <li>• 2015–2018: PQRS, MU, VBM continue.</li> <li>• 2019: 4% (Extra bonus possible)</li> <li>• 2020: 5% (Extra bonus possible)</li> <li>• 2021: 7% (Extra bonus possible)</li> <li>• 2022 &amp; after: 9% (Extra bonus 2022–2024)</li> </ul> All physicians could earn a bonus if they meet MIPS quality standards. <b>Extra bonus 2019–2024:</b> Up to 10% for exceptional performance (up to \$500 million/year). MIPS has more accurate assessment, scoring, flexibility, predictability than under PQRS, MU, or VBM. MIPS abandons current VBM "tournament" model (requiring penalties to equal bonuses).
<b>EHR Meaningful Use (MU)</b>	No clear timeline or enforcement tools to achieve interoperability.	MU measures count 25% in MIPS. Goal is interoperability by 2018; Secretary may adjust penalties/decertify EHRs if this is not achieved.
<b>Alternative Payment Models (APMs)</b>	No guaranteed payment update or bonus for physician participation in medical homes, ACOs, or other existing APMs. Limited support for physicians to develop new payment models.	5% Bonus payment for 2019–2024 for successful participation in eligible models. APMs must bear more than nominal risk, or be a qualifying medical home. Physicians can propose new APMs. \$20 million/year (2016–2020) in technical assistance for small practices to develop new models or participate in MIPS.

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PHYSICIAN HEALTH MATTERS

# Establishing a Culture of Trust Through Ongoing Feedback

BY DEBRA GROSSBAUM, ESQ.  
PHS GENERAL COUNSEL

Giving feedback is essential. This was a significant theme at an educational course recently co-sponsored by the Massachusetts Medical Society and Physician Health Services titled, "Managing Workplace Conflict, Improving Leadership and Personal Effectiveness."

The course, sponsored in part by a grant from The Physicians Foundation, provided physicians with tools to improve the medical work environment by strengthening communication styles and offering specific approaches to enhance workplace interactions.

One pearl of wisdom that was repeated throughout the course was the importance of sharing constructive feedback, both negative and positive, on a regular basis. While this is a basic concept for many, sharing positive feedback is often overlooked, and providing negative feedback is often avoided. As a result, when a significant event takes place that requires prompt attention, the feedback is often given and received with angst, defensiveness, and resentment. Without first opening the channels for positive communication, feedback can become contentious and ineffective.

Jo Shapiro, M.D., from the Center for Professionalism and Peer Support at Brigham and Women's Hospital helped identify many reasons why feedback tends to be avoided. She noted that medical leaders often refrain from providing feedback because they worry that it will involve a significant time commitment, a precious commodity in medicine these days. However, she said, it is important to balance this commitment with the time drain on an organization following escalated behaviors that result in a crisis.

Other barriers to providing timely feedback include underestimating the importance of addressing what may be seen as a pattern of lower-level problems, a general skepticism that providing feedback will result in measurable change, and an inner need for leaders to retain "good guy" status in the eyes of their colleagues and staff, said Dr. Shapiro.

Moreover, giving constructive but negative feedback is just plain difficult because of the emotions it arouses in the feedback giver as well as the feedback receiver. Despite these obstacles, feedback is essential to developing a medical workplace environment of trust and respect that can respond to challenges as they arise.

Dr. Shapiro instructed that not all feedback is created equal. In order to be effective, feedback must be timely, specific, and provided in a way that allows the recipient to develop insight into the impact of his or her actions on others. It is crucial to listen to the feedback receiver's perspective on why he or she chose such behaviors; without this understanding, it is unlikely that the feedback will have the desired impact, which is learning and behavior change. This insight is best developed when a culture of trust has been established in the workplace.

While developing trust within a large organization may seem daunting, it can be done, over time, and in many ways, such as giving frequent, timely, and accurate offerings of feedback, including positive feedback. When physicians feel acknowledged and recognized for the good work they do, they feel safer hearing the necessary constructive feedback that may sound or be more negative. However, it is essential to be specific. Just as individuals don't respond well to unsupported negative feedback, they are equally unlikely to respond to generic nonspecific praise. Generic praise or criticism is not helpful in describing

specifically what behaviors should be repeated and what behaviors need to change.

Building on this theme, Melissa Brodrick, ombudsperson for the Harvard Medical, Dental, and T.H. Chan Public Health Schools, emphasized that to best achieve their underlying goals, leaders benefit from understanding various styles of addressing conflictive interactions and considering the potential impact of power differentials. If the goal is behavior change, often the recipient of the feedback needs to be on board with the goal and be willing to make changes. This can best occur when the recipient of challenging feedback has a chance to feel heard and to share his or her perspective.

However, experts agreed that it is essential to remain clear and consistent with parameters and expectations so that participants in the information exchange are not blindsided as to consequences that will take place if changes are not achieved.

The course described above will next be offered on November 19 and 20, 2015.

For more information please contact Jessica Vautour, Education and Outreach Director at Physician Health Services, Inc., at (781) 434-7404 or visit [www.physicianhealth.org](http://www.physicianhealth.org).

## Mentor Students by Facilitating a Medical School Course

The Committee on Senior Volunteer Physicians wants to bring to your attention a volunteer opportunity as a course facilitator for the Boston University School of Medicine Integrated Problems course. The course is a requirement for all first- and second-year medical students and physician volunteers are needed to help guide the students as they integrate information from other classes and independent study groups in order to make a correct diagnosis.

The committee is hosting an orientation and training session on Wednesday, June 10, 2015, from 9:30 a.m. to 1:00 p.m. at MMS Headquarters in Waltham. Megan Young, M.D., the course director, will conduct the session. Lunch will be served.

To register to attend the session, please contact Carolyn Maher at [cmaher@mms.org](mailto:cmaher@mms.org) or (781) 434-7311.

## Graduating Medical Students



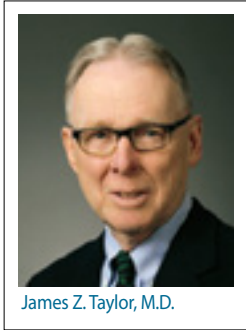
- If you are staying in Massachusetts, talk with your residents-fellows program director about FREE MMS Membership or simply ask your program coordinator to submit a 2015 program roster to activate the MMS benefits for you and your colleagues.
- Beginning your training out of state? Maintain your membership through December 2016 at no cost. Watch your mail for more information.

### Questions?

[groups@massmed.org](mailto:groups@massmed.org) | 800-322-2303, ext. 7748

## 2015 Senior Volunteer Physician of the Year Award

The Committee on Senior Volunteer Physicians is pleased to announce that it has selected James Z. Taylor, M.D., of North Eastham as the recipient of the 2015 Senior Volunteer Physician of the Year Award.



James Z. Taylor, M.D.

Dr. Taylor, a member of the Society since 1990, is an internist whose career includes practicing in the United States Navy as a flight surgeon for six years, running a private practice in Geneva, New York, for 20 years and practicing on Cape Cod for a decade. In 2004, Dr. Taylor joined the Duffy Health Center as a volunteer physician. The Duffy Health Center serves people who are homeless or at

risk of homelessness on Cape Cod, and Dr. Taylor has played an integral part in the provision of medical services to this overlooked population.

Dr. Taylor has also been active with CapeAbilities, a non-profit organiza-

tion that provides services for adults with disabilities, the Eastham Board of Health, Dartmouth College Club of Cape Cod, and the Alumni Council of Dartmouth College. He was also president of the board of directors for Happiness House in Geneva, New York, a nonprofit organization for preschool children with mental retardation and disabilities.

### ACROSS THE COMMONWEALTH

#### District News and Events

##### WEST CENTRAL REGION

**Berkshire — Legislative Breakfast.** Fri., June 5, 7:30–9:00 a.m. Location: Berkshire Medical Center, Pittsfield.

**Hampshire — Legislative Breakfast.** Fri., June 12, 7:30–9:00 a.m. Location: Cooley Dickinson Hospital, Northampton.

#### Statewide News and Events

**Arts, History, Humanism, and Culture Member Interest Network — Bird Banding.** Sat., May 30, 9:00 a.m.–noon. Location: Joppa Flats Education Center, Newburyport. **Herb Workshop.** Sat., June 6, 10:00 a.m.–1:00 p.m. Location: MMS Headquarters, Waltham.



MASSACHUSETTS  
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## Global Health Fair

### Description

This full-day event will bring people together from a variety of nations, disciplines, perspectives, academic institutions, and non-governmental organizations for education, discussion, and networking on global health issues. The meeting will incorporate lectures eligible for CME credit, guided discussions, and ample opportunities to establish personal contacts in a comfortable atmosphere. Volunteer opportunities — both domestic and international — will be presented.

The CME portion of the conference will include sessions on topics including Practical Aspects of Conducting Surgery in Resource-Limited Regions, Malaria and Tuberculosis Management, Global Issues in Oral Health, HIV Care among Refugees, and more.

### Audience

Physicians, clinicians, and representatives from organizations working in and researching global health in various countries.

### AMA Credit Designation Statement

The Massachusetts Medical Society designates this live activity for a maximum of 5.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

### Accreditation Statement

The Massachusetts Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

**Saturday,  
May 16, 2015**  
9:00 a.m. to 5:00 p.m.  
Massachusetts Medical Society  
Headquarters at Waltham Woods,  
Waltham, Massachusetts

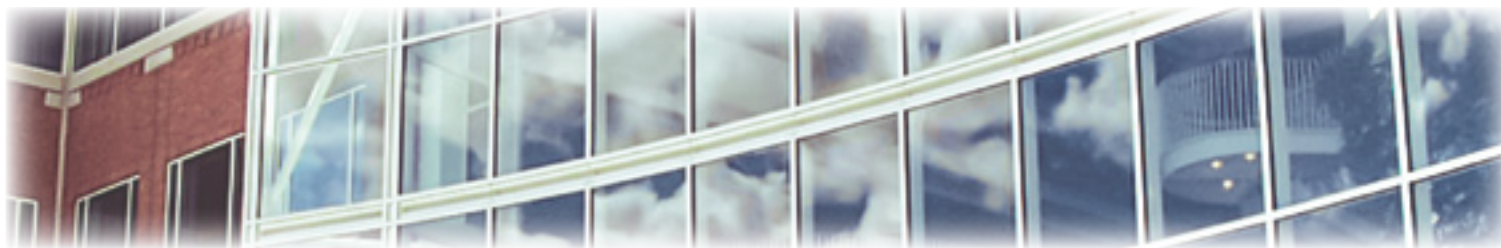
### SPACE IS LIMITED!

To register for this event or for more information, please call **800.843.6356** or visit [www.massmed.org/GHF2015](http://www.massmed.org/GHF2015)



Photos by Jill Cricones

The BU School of Medicine hosted medical students, residents, and new physicians at *Reality Medicine: Opportunities and Keys to Success for a Career in Medicine Today*. The program gave attendees the opportunity to engage with and learn from experienced physicians from a variety of specialties, career paths, and backgrounds.



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  - > Final Meaningful Use Rules
- 2 > **President's Message: Looking Forward**
- 3 > **The Importance of Staff Performance Appraisals**
  - > ICD-10: Adjusting Encounter Forms and Superbills
- 4 > **Men's Health Conference June 18**
  - > Older Driver Safety Summit
- 5 > **Improved Decision Making for Incapacitated Patients**
- 6 > **Establishing a Culture of Trust Through Ongoing Feedback**
  - > Mentor Medical Students by Facilitating a BUSM Course
- 7 > **2015 Senior Volunteer Physician Award**
  - > Global Health Fair May 16



MASSACHUSETTS  
MEDICAL SOCIETY

# VITALSIGNS

VOLUME 20, ISSUE 5, MAY 2015

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## MMS AND JOINTLY PROVIDED CME ACTIVITIES

### LIVE CME ACTIVITIES

Unless otherwise noted, event location is MMS Headquarters, Waltham.

#### Women's Leadership Forum: Leadership at Every Level

Sat., September 26, 2015 [Save the Date](#)

#### 2015 Women's Health Forum — Women's Health Across the Life Span: Adolescent to Geriatric

Fri., November 6, 2015 [Save the Date](#)

### ONLINE CME ACTIVITIES

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

#### Risk Management CME

##### NEW Finance 102 (3 modules)

- Module 1 — Revenue Cycles Case
- Module 2 — Finance and Budgeting Case Study
- Module 3 — Compensation Planning Case Study

##### Electronic Health Records Education (3 modules)

- Module 1 — Guide to Health Information Technology
- Module 2 — Making Meaningful Use Meaningful
- Module 3 — Meaningful Use Stage 2

##### End-of-Life Care

- End-of-Life Care (3 modules)
- The Importance of Discussing End-of-Life Care with Patients
- *Legal Advisor*: Advance Directives

##### Pain Management

- Principles of Palliative Care and Persistent Pain Management (5 modules)
- 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

##### Medical Marijuana (4 modules)

- Module 1 — Medical Marijuana: An Evidence-Based Assessment of Efficacy and Harms
- Module 2 — Medical Marijuana in the Commonwealth: What a Physician Needs to Know
- Module 3 — Medical Marijuana in Oncology
- Module 4 — Dazed and Confused: Medical Marijuana and the Developing Adolescent Brain

##### 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

- Genetically Modified Foods: Benefits and Risks
- Physician Employment Options in the Health Care Environment
- 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
- Preventing Overuse of Antipsychotic Drugs in Nursing Home Care



CME CREDIT: These activities have been approved for *AMA PRA Category 1 Credit™*.

FOR ADDITIONAL INFORMATION AND REGISTRATION DETAILS GO TO  
[WWW.MASSMED.ORG/CMECENTER](http://WWW.MASSMED.ORG/CMECENTER), OR CALL (800) 843-6356.