Dallas Medical Journal

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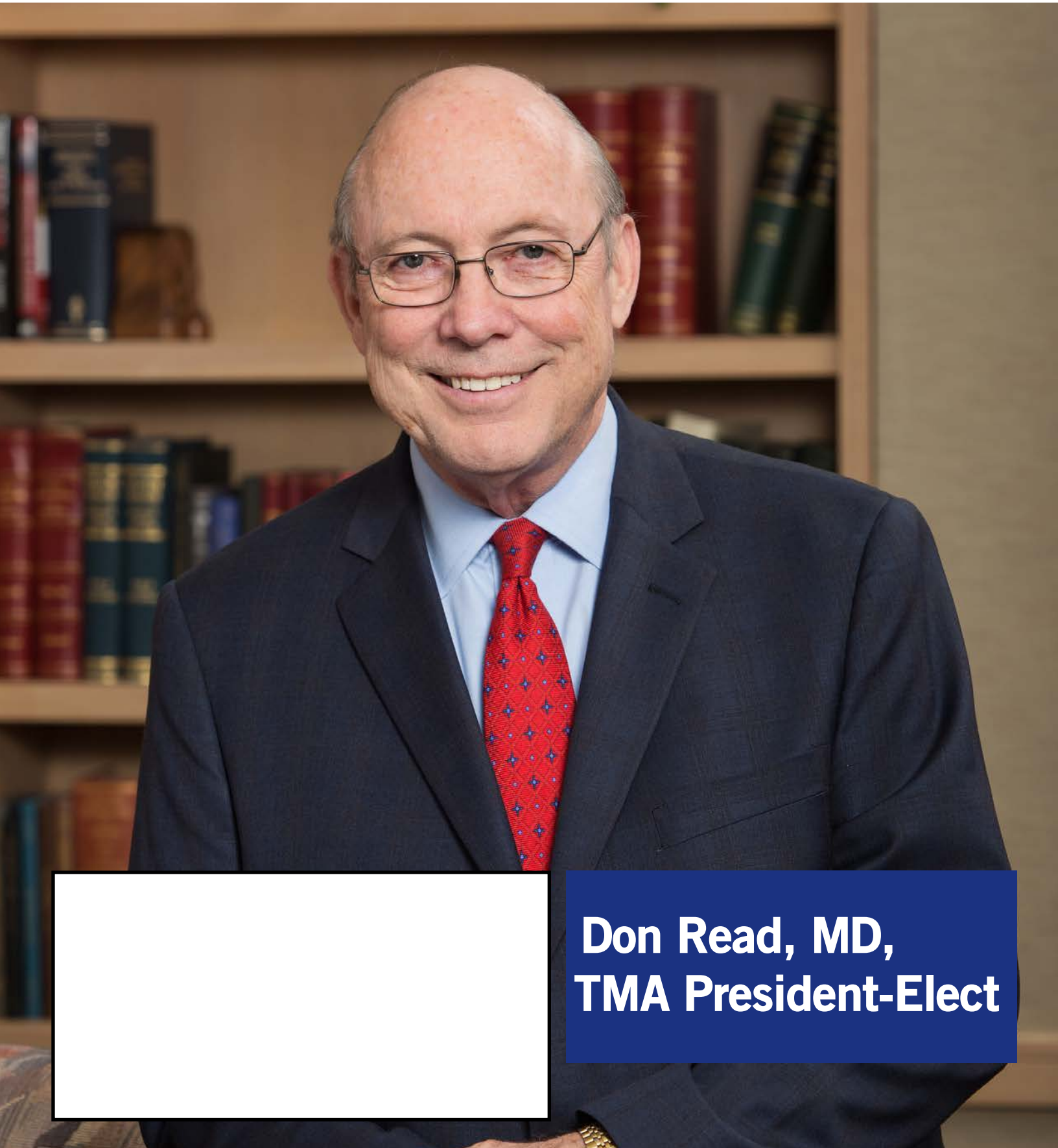

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Phone: 214-948-3622, FAX: 214-946-5805
www.dallas-cms.org
Email: steven@dallas-cms.org

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About the cover: Don R. Read, MD will be installed as the 151st president of the Texas Medical Association on April 30 during TMA's TexMed held at the Hilton Anatole in Dallas. Be part of the celebration by registering at www.texmed.org. TexMed is free for TMA members.

Letters to the editor may be submitted to **steven@dallas-cms.org.**

President's Page
Celebrating Diversity

Lee Ann Pearse, MD

Diversity: "the quality or state of having many different forms, types, ideas, etc.," "the inclusion of individuals representing more than one national origin, color, religion, socioeconomic stratum, sexual orientation, etc."

When I was growing up in my small town in eastern Colorado, I did not spend a lot of time thinking about diversity, as there was very little of it at the time in the way most of us think of diversity. Diversity at that time was more along the lines of who lived in town and who lived "in the country," who was from Yuma and who wasn't, i.e., who was from Denver. In our Lutheran church, there were those who were Missouri Synod and then there were those who were not. There was not a lot of talk about things such as race, different countries of origin, gender politics. I and my friends worried more about grades, what to do after high school, sports, etc.

When I got to the University of Colorado at Boulder, which was often considered the Berkeley of the east, I worried, again, about grades like everyone else in premed, but I never worried about not fitting in. It was a fabulous place to go to school because it was so much different from where I grew up and it challenged me to learn so much more. It seemed to be a very inclusive environment. In medical school I became involved in organized medicine and ultimately became involved with the AMA. Some questioned why I would get involved with the AMA as it was believed to favor older white gentlemen and that I could not make a difference. My answer was that it made more sense to get involved from the inside in order to change it, rather than challenge it from the outside.

So what does that have to do with today? Shortly after I began my year as President of DCMS, one of my colleagues at Medical City stopped me and, jokingly, asked if he should congratulate me or offer his condolences. He asked me how I was going to get so many different physicians to fall in line. I replied that I wasn't going to even try. After that encounter, several other people commented on how wonderful it is that the DCMS Board of Directors is so diverse. Until then I had not really thought about the BOD in those terms but when looking at the picture of the Board on the cover of the February Dallas Medical Journal, I couldn't agree more! Recently I was proud to be present at the first meeting of the Women in Medicine Committee, chaired by Sue Bornstein, MD. Again, a tremendous amount of diversity with an amazing group of women.

Why discuss diversity and why does it matter? It matters because the House of Medicine itself is so much more diverse than what organized medicine appears to represent at times, and it is time that it broaden its horizons to do so. The fact that people are commenting on the diversity of the DCMS BOD is exciting and shows that we are already going in the right direction. For example, if you look at the current statistics, women make up between 26 percent and 30 percent of both the DCMS and the TMA. Women make up 38 percent of the Board. More than 50 percent of the members of each of the two organizations are white. Approximately 44 percent of TMA members are older than 50, 43 percent of DCMS members are older than 50. Looking at the February DMJ cover photo, obvious diversity exists in gender, race, and age on the DCMS Board. Diversity in the professions is represented. Academia is represented, as is private practice. Public health is represented as is high level practice management. Some are married, some are single, some have children, some don't. There are those in group practices, others in solo practice, some early in their careers, others ready to slow down. They all come to the meeting with their own set of experiences, both personal and professional, and provide invaluable advice and insight. This highlights one of the many strengths of DCMS, this diversity that is promoted and celebrated.

DCMS board members attend the 2016 Installation and Awards Dinner.
Back row: DCMS board members Drs. Alexandra Dresel, Pranavi Sreeramoju, Thomas Zellers, Joseph J. Carlos, Mark Casanova, Carlos E. Pancorvo, R. Elizabeth Kassanoff, and Wendy Parnell.
Front row: DCMS executive committee members Ruben L. Velez, MD, secretary/treasurer; Jim Walton, DO, immediate past president; Lee Ann Pearse, MD, president; and John T. Carlo, MD, president-elect.
Not pictured: DCMS board member Brad McGowan, MD

I truly believe in fostering an environment that encourages all points of view. When we talk about medicine having one voice, it is not to imply that only one person's voice should dominate, but rather a collection of many voices working together for solutions. It is this diversity that will continue to bring solutions to this community and the patients and colleagues we serve. Regarding my MCD colleague, my response about not trying to get people in line was not to abandon my role as a leader, but rather to invite people to feel welcomed in DCMS for who they are, not what we think they should be. I am excited that DCMS is poised to foster that environment. The more people we can bring to this family, the better it will be for all of us. **DMJ**

"Be the change you want to see in the world." — Mahatma Gandhi

Ryan Kirkham

'It all boils down to problem-solving.'

Growing up as the son of a prominent physician, Dr. Wayne Kirkham, and a respected learning specialist, Dr. Sally Kirkham, Ryan Kirkham knew early on that his eventual profession would be one that helped people.

"My parents spend their professional lives helping others, and I know how rewarding that can be," he says. "Being a family lawyer gives me the opportunity to help others every day. It all boils down to problem-solving. My dad, my mom and I all help people solve their problems and improve their lives."

YOUR FUTURE OUR FOCUS

Ryan, who is fluent in German, has spent considerable time in Germany and Austria visiting family there. He finds that his fluency in a second language and culture has enhanced his ability to be his clients' advocate.

"Being able to define what motivates others can be incredibly helpful when settling disputes," says Ryan, one of 14 family lawyers at Orsinger Nelson Downing & Anderson. "Lawyers who use scorched-earth tactics don't do their clients any favors. My goal is to get my clients to the next chapter of their lives, and being able to understand what the other side wants – even if they aren't communicating it very well – is incredibly helpful."

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**By appointment*

DCMS members and their families are invited to attend the

DCMS Spring Picnic

Saturday, April 23

11 a.m. – 2 p.m.

The Dallas Arboretum and Botanical Gardens

8525 Garland Road, Dallas

Lunch, door prizes and activities for the kids!

The cost is $15 per family.

RSVP by Friday, April 15.

Fax this form to 214.946.5805, or contact Cara Jaggers at 214.413.1423 or cara@dallas-cms.org.

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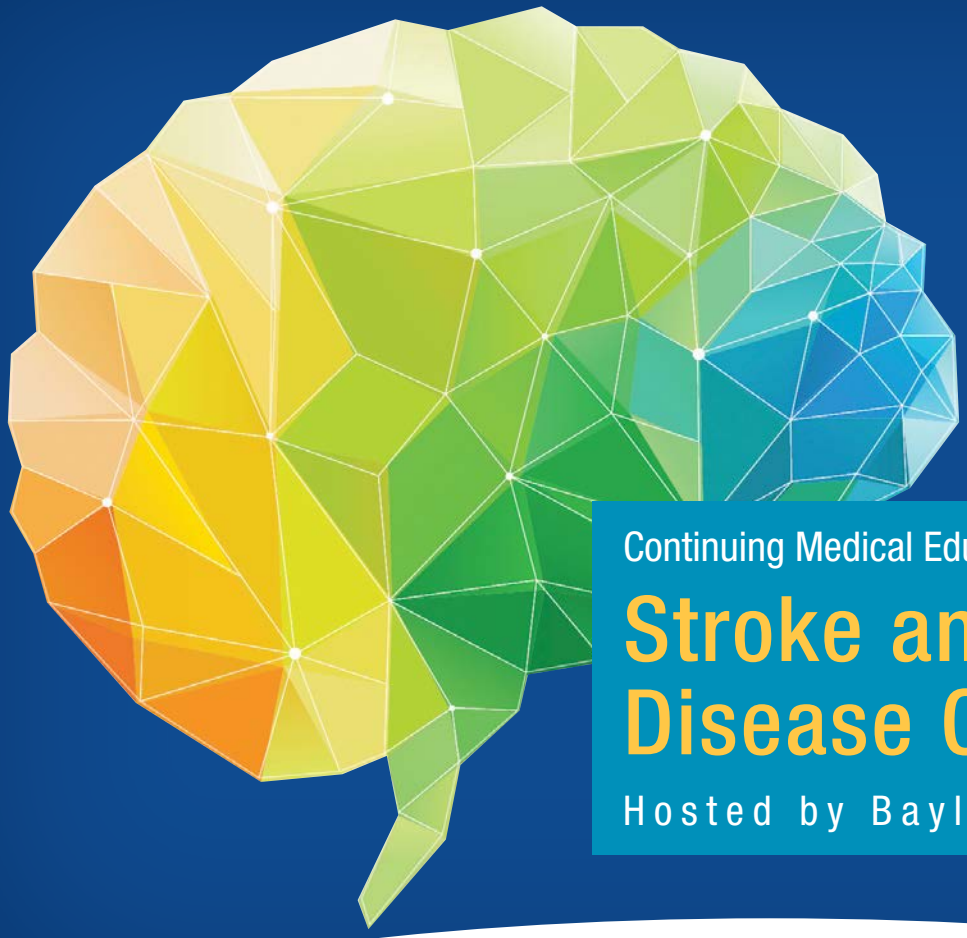

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Hosted by Baylor Scott & White Health

Saturday, May 21, 2016
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- Cutting-edge interventional treatments for cerebral aneurysms
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- Cognition and memory: the influence of diet and nutrition

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The A. Webb Roberts Center for Continuing Medical Education of Baylor Health Care System, Dallas is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Retired Physician's Club

On March 16, more than 45 DCMS retired physicians came together for lunch and to hear a presentation from RPC member Charles Tandy, MD. His presentation, titled, "A Visit with the Books – History of Medicine and Much More," featured his large collection of historic books and was well recieved by all who attended.

The Role of a Virtual Chief Information Officer in Your Practice

by Keith Barthold, president and CEO, DKBinnovative; and William Mays, partner, DKBinnovative

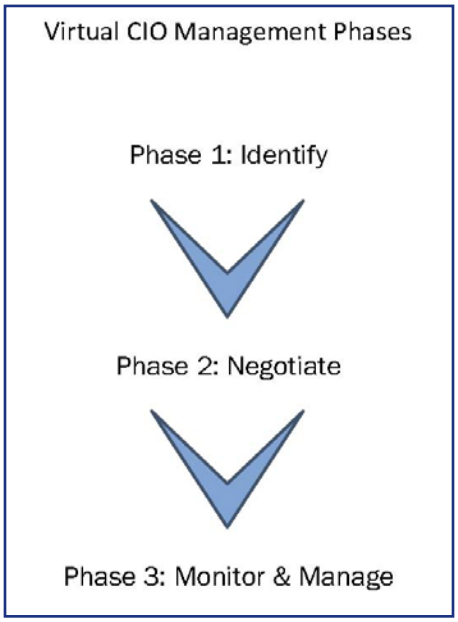
Running a business often requires a lot of resources, such as internet providers, cloud services, phone systems, network setups, and much more. New technology in today's physician office is more than just the electronic medical records vendor. From the tablets, computers, and telephones in the patient rooms to the televisions in the waiting rooms, technology is meant to be useful and hopefully provide a positive experience for physicians and their patients. This positive experience comes at a price. According to the 2013 MGMA-ACMPE cost survey report, information technology expense brings in only 2.2% of total medical revenue for physician offices in our region. As a result, practices of all sizes need to choose their vendors and new technology wisely.

The Virtual CIO

A benefit of maintaining your own practice is your autonomy. You choose your vendors. You decide how best to build the technology foundation and infrastructure. You decide how much you want to spend for specific services. Where the problem lies is in the amount of time you and your office staff devote to researching and negotiating the most appropriate tools for your practice. Whereas large healthcare organizations can afford an employee to oversee the strategy and cost containment for technology services, smaller physician offices cannot afford this luxury. This is when smaller practices should consider contracting with the virtual Chief Information Officer (CIO).

A virtual CIO is a contractor or company in charge of your technology planning. The virtual CIO will:

- Assess your office needs
- Help set a budget for technology expenses
- Identify the most appropriate vendors
- Negotiate the terms (pricing, warranties, service add-ons)
- Manage the vendors and provide service coordination



Identify Your Technology Objectives

The first priority for the virtual CIO will be to meet with your office staff and provide decision support. Decision support will narrow the technology needed for the office and vendors. The virtual CIO will need to understand the extent your office relies on technology for operation. The contractor should also understand the role you want technology play. For example, how do you want patients to schedule their appointments — online or through the front office or both? Do you want to use patient portals? How can patients contact your office after hours? What applications do your employees need to become more efficient? What are your security requirements? What are your data access needs?

The decision support phase also includes understanding your growth plans. How many offices do you want to have in the future? What type of ancillary services do you want to provide to your patients? Discussing your growth plans will help anticipate your future technology needs. It will also define the vision of where you want your practice to be and set targets for improvements down the road.

Negotiation and Pricing

When appropriate vendors are identified, a virtual CIO will negotiate the rates, terms and services with vendors and present your office with the options available. In addition, the virtual CIO will outline your potential profits and losses with each vendor in order to help you decide if you want to leverage your assets or purchase the services/tools. It is this forecasting service and decision support that distinguishes the virtual CIO from discounted tools offered by group purchasing organizations.

Monitoring and Management

Once you have signed on the dotted line with your vendors, virtual CIOs are responsible for the installation and execution. Small practices do not have an IT department to call when a specific application is not working. Managing all the different vendors can be extremely time consuming and difficult. If a problem arises with any of your services, office staff will only need to call the virtual CIO and not the various vendors. Your contractors are responsible for ensuring the issues are resolved. The comprehensive management should reduce disruptive productivity gaps thereby allowing you and your staff to maximize the time with your patients.

Disaster Planning

In addition to management, virtual CIOs also work with you to plan, prevent and

minimize the impact of disasters that can compromise and destroy your data.

1. Identify & Prioritize. Your contractor will identify and rank all weaknesses and threats according to your practice's susceptibility to these risks.

2. Simulate Severity. Contractors run most-likely and worst-case-scenario simulations to determine the severity of impact the threats could have on your practice.

3. Design Disaster Recovery Solution. A customized recovery plan should be designed based on the scenario simulations to ensure the complete recovery of your operations within a timeframe you can accept.

Data Backups and Protection

Even if you take all the precautionary steps, accidents can still happen – files are accidentally deleted, a hard drive fails. A virtual CIO will design a Business Continuity Plan to help expedite the process of getting your systems working again. This is often done by providing remote data recovery backups. Encrypted, fault-tolerant backups can be done both in your office and offsite in secure, data centers.

Conclusion

From EHR and internet service to practice management software, by spending money on technology, practices expect increases in productivity and efficiency within the office, ultimately, leading to increased health of the patients. Frustration occurs when the investments do not lead to the desired goals. Furthermore you and your office staff may not know which companies to contact, or have the time to comparison shop. The use of a virtual CIO may cut your operating expenses by negotiating contracts and decreasing hassles with vendors so you and staff can spend more time with patients.

DMJ

Keith Barthold serves as the President and CEO of DKBinnovative and William Mays serves as Partner. DKBinnovative is a DCMS Circle of Friends Member that provides IT services remotely, onsite, or through managing vendors. Contact them at 469-828-2468 or www.dkbinnovative.net.

> ***"Whereas large healthcare organizations can afford an employee to oversee the strategy and cost containment for technology services, smaller physician offices cannot afford this luxury. This is when smaller practices should consider contracting with the virtual Chief Information Officer."***

Does Your Practice Need an IT Audit?

If you feel that any of the below are a concern to your practice, consider scheduling an IT audit with a virtual CIO service company.

- Do you know if your office is compliant with HIPAA, HITECH, Texas HB 300, Omnibus, and all government regulations and requirements?
- Does your staff complain about your EMR/EPM support?
- Do you have HIPAA-compliant email systems?
- Are you comfortable with your network regarding data breaches?
- Do you have advanced backups for your data?
- Are your voice phone systems adequate to handle current call volumes?
- Does your office have interfacing solutions for integrating lab systems and portals?
- Do you notice an increase in your staff's complaints about any of your software applications?
- Does your practice consistently have trouble logging in?
- Are you worried about the security risks within your practice?
- Does your office manager spend considerable time on the phone speaking to the help desk for the vendor?

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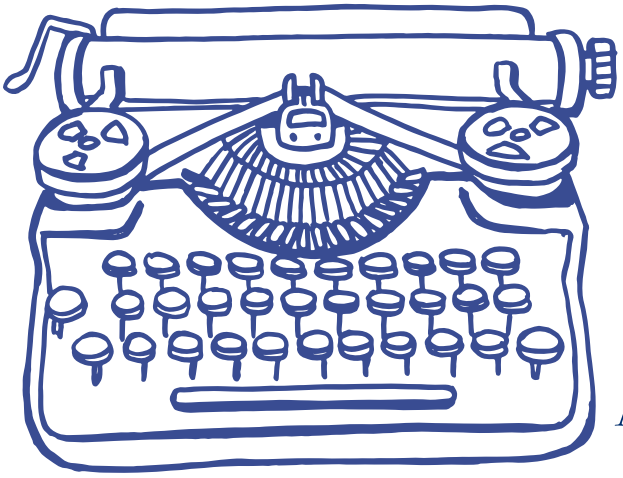

30th Annual Conference of the Professions

April 22 9 a.m. – Noon

The Annual Conference of the Professions brings together members of medicine, law and theology in the Dallas area to discuss common challenges facing these professions. The University of Texas Southwestern Medical Center, the accredited sponsor, is sponsoring this activity with the Dallas County Medical Society, Dallas Bar Association, Southern Methodist University Cary M. Maguire Center for Ethics and Public Responsibility, SMU Dedman School of Law, and SMU Perkins School of Theology.

All DCMS members are invited to attend this year's conference, titled "Coming Home: The Professions Supporting Veterans" will be from 9:00 a.m. to 12:00 Noon, Friday, April 22, 2016, in the Meadows Museum — Southern Methodist University, 5900 Bishop Blvd, Dallas, TX 75205. Please note the new location. Parking is available in the Meadows Museum garage.

The keynote speaker will be Elspeth Ritchie, MD, MPH, Colonel, US Army (Ret), Chief Clinical Officer, Department of Mental Health, for the District of Columbia. Dr. Ritchie will explore how the professions can provide healthy and effective responses to the needs of military veterans and their families concerning issues including PTSD and moral injury, legal concerns, homelessness, job placement, family reintegration and cultural adaptation. This live activity has been approved for AMA PRA Category 1 Credit(s)™.

To attend, you must register online at https://www.eventbrite.com/e/30th-annual-conference-of-the-professions-tickets-22662115999. The cost to attend the event is $28, which includes CME credit. For questions or assistance with registering, contact Connie Webster, DCMS Chief Operating Officer, at 214-948-3622 or connie@dallas-cms.org.

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TexMed Speakers and Topics

Martin A. Makary, MD

Art, Assassination, and America: How Transparency Disrupts an Industry

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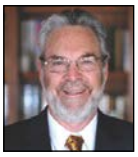

Mark G. Dotzour, PhD

Economic Outlook: What's in Your Future?

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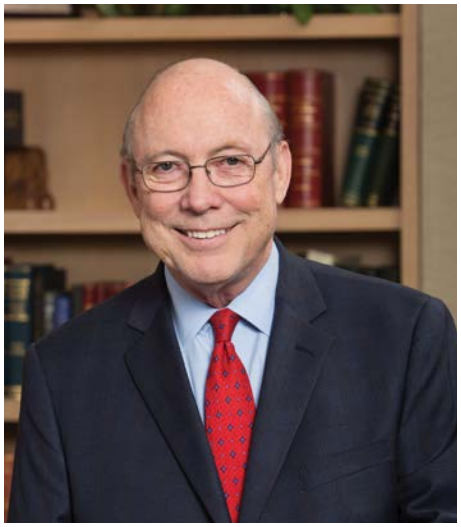
Texas Medical Association

Physicians Caring for Texans

DCMS Member, Don R. Read, MD, to be Installed as TMA President During TexMed in Dallas

Also during TexMed, you can join your DCMS colleagues Lee Ann Pearse, MD, DCMS president and host city chair, and Deborah A. Fuller, MD, TMA Foundation president, for the TMA Foundation Gala.



Don Read, MD

Don R. Read, MD will be installed as the 151st president of the Texas Medical Association on April 30 during TMA's TexMed held at the Hilton Anatole in Dallas. Be part of the celebration by registering at www.texmed.org. TexMed is free for TMA members.

During TexMed, you can join your DCMS President, Lee Ann Pearse, MD, and your DCMS colleague Deborah A. Fuller, MD, TMA Foundation president, for a glamorous throwback to old Hollywood style at the TMA Foundation's 2016 Gala — *As Time Goes By: An Evening in Casablanca*. The gala will be on April 29 and is also at the Hilton Anatole. Dr. Pearse and her husband, Einar Vagnes, are Host City Chairs for an evening inspired by the 1944 Academy Award winning film, Casablanca. The gala includes two guest receptions, a stunning silent auction, an elegant dinner with a spirited game of Heads or Tails and a chance to outbid your friends on a trip to Paris in the live auction! Your attendance supports TMA's award-winning initiatives such as Walk with a Doc Texas, Be Wise — Immunize, Hard Hats for Little Heads, and more.

Advance tickets* to the foundation's gala are available for $200 each or get VIP tickets for $250 by calling TMAF (a 501(c)(3) organization) at 800-880-1300, ext. 1466, or 512-370-1466. Tickets also are available on TMAF's website at www.tmaf.org. **DMJ**

**Ticket prices increase to $225 for general guest tickets and $275 for VIP guest tickets after April 22, 2016.*

DCMS Physicians Judge Local Science Fair Projects

by Matt Sloan, MD

The 2016 Beal Bank Dallas Regional Science & Engineering Fair took place on Saturday, Feb. 27. Area high school students submitted some 1,000 projects in varying categories of life and physical sciences, which awed the DCMS physicians who volunteered to judge the event for special awards given by the DCMS Foundation. Each of the winning students was honored at a banquet hosted at Southern Methodist University on March 22.

On the cool morning of February 27, 2016, we brave judges — veterans Drs. Sarah Helfand and Gordon Green and novices Drs. Nancy Hitzfelder, Preeti Malladi, and Matt Sloan — fought through parent-student traffic to get to the Beal Bank Dallas Regional Science and Engineering Fair at Fair Park. Your humble reporter even spilled his coffee in his lap on the way there just to get his klutz vibe on. It was also slightly disconcerting that I didn't need an ID to be directed immediately to the judge's table — guess it was the gray hair! We judges strategized over a decent free breakfast served on small plates and coffee. Next we divided into 2 teams: Drs. Helfand and Sloan, Team A; and Drs. Green, Hitzfelder and Malladi, Team B. Armed with pens, tablets, and some loose criteria, the 2 teams set forth with the arduous task of deciding whose was the best project.

DCMS physician judges for the DCMS Foundation Special Awards were (left to right) Drs. Matt Sloan, Sarah Helfand, Nancy Hitzfelder, Preeti Malladi, and Gordon Green. Veteran judges who were unable to attend this year are Drs. Tya-Mae Julien, Brenda Mears, and Archana Rao.

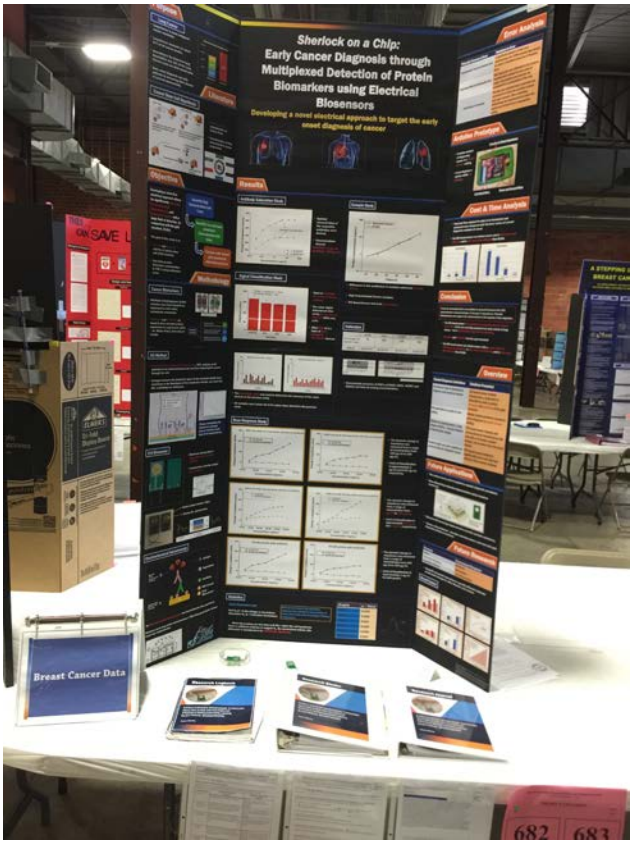
On Team A we saw various very well thought-out and presented papers, some elucidating what is already known — like how dialysis works, and proving that it does work, which was certainly valuable. But some were quite creative and very impressive. The one that impressed us the most was the winner entitled "Sherlock on a Chip: Early (lung) Cancer Diagnosis through… Protein Biomarkers… using Electrical Biosensors." This in essence increased the detection sensitivity from a concentration of 10 to the minus 6 Molar to "comfortably 10 to the -15 Molar," or from a sample requiring bronchoscopic lavage of tissue (current ELISA method) to detect cancer cells to serum screening. Strangely enough, I think patients would find it much more palatable to get their cancer screening via venipuncture than an annual broncho-endoscopy! The presenter was a very nice young man who not only invented the aforementioned chip but also a portable machine that could actually do the screenings on location. I advised him to patent the whole thing, and he could retire by age 20.

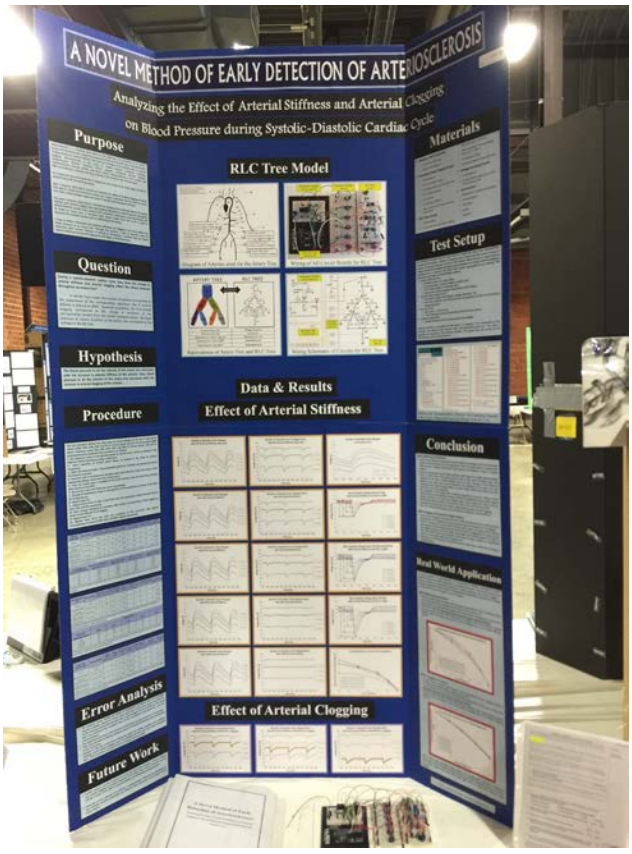
The Senior second place winner was found by Team B — "Early Detection of Arteriosclerosis via Analyzing Effect of Arterial Stiffness/Clogging on Blood Pressure during the Cardiac Cycle." This exhibit showed impressive hypothesis/statistical analysis and electrical modeling of the arterial tree called the RLC tree circuit, interpreted via the "arduno code." Using these sophisticated electrical modeling tools and extrapolation, the investigator was able to generate detection curves reflecting arterial stiffness. The key point was this: "Once the systolic and diastolic pressure ratios are measured for a patient, and are normalized to typical healthy values, the early detection curves can be used to identify the percent of arterial stiffness and arterial clogging present. Both of these early detection curves, alone or in combination, will offer a significant improvement over conventional methods that are limited to

diagnosis at higher levels." Because this study could lead to an early diagnosis of arteriosclerosis, we found it impressive and relevant.

In addition to judging the DCMS Special Awards, our team was asked to judge exhibits in the Biomedical and Health Sciences category, which is open to 11th grade students and below. Frankly, some of the exhibits in this category blew me away, particularly the unequivocally most impressive of these — and the winner in this class — which was a computer program devised by the student investigator that conceivably could connect blood glucose monitoring with insulin infusion pump in diabetics. What we have today is just more or less constant insulin infusion punctuated by boli for high glucose numbers. The student investigator quite rightly pointed out to us that an insulin pump which simply reacts to the current recorded blood sugar would have disastrous outcomes in that it would inevitably overshoot with very high or low glucoses as a result. The only way these systems could be connected is if a program could accurately predict what a blood sugar will be in 30 minutes to 2 hours and thus secrete insulin in an anticipatory manner. Therefore, this novel program took the blood sugar values and factored in meals, exercise, and numerous other variables in a self-learning artificial-intelligence modality, thereby predicting the future blood glucose curve. In graphic form the student demonstrated that even after apparent minimal input his program predicted very accurately the patient's 24-hour blood glucose curve (the predicted curve was pretty much superimposed on the actual one in terms of mg/dl versus time). Next year, I understand, he will try to pair the program with the insulin pump to effectively create an artificial pancreas, which I think will be astounding!

What I came away with was a lot of good feeling and hope for the future. These young people had creative, sharp, scientific minds, which certainly bodes well for upcoming medical research in America. The whole process was fun, and I honestly learned quite a bit. I hope that I'll be allowed to return to judge next year! **DMJ**





The Dallas regional science fair began in 1957 by Southern Methodist University, DCMS Alliance, and the Dallas-Fort Worth Association on Scientific Societies, and is the oldest continuously running regional fair in the United States.

DCMS Alliance was prominent on the organizing committee and organized the Special Awards program.

Over the years, various companies, such as The Dallas Morning News and Toyota, have sponsored the fair. Beal Bank is now the title sponsor.

If you would like to help judge the DCMS Foundation Special Awards next year, please contact Jackie Campbell, DCMS director of finance, at campbell@dallas-cms.org.

In addition, Science Fair organizers are in need of highly qualified judges for the Biomedical and Health Sciences category. If you can help, please contact Dr. Simon Dalley, president of the Dallas Regional Science & Engineering Fair, at sdalley@mail.smu.edu or 214-768-2109.

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What is Medicare Value-Based Care?

by Amy Lynn Sorrel

The alphabet soup of Medicare's quality reporting programs has not been easy for physicians to swallow, or follow. But for many, they are an entry point to a fast approaching value-based care system that seeks to break the cycle of high healthcare spending and reorganize and reward care delivery around better patient health. Medicare's January 2015 announcement of specific goals and timelines for transitioning to a value-based payment system also should create a sense of urgency and opportunity for physicians. Under any system, physicians need to think about quality as well as cost.

What is value-based care?

Simply, value-based care means achieving the best outcomes at the lowest cost. Ronald S. Walters, MD, a member of TMA's Council on Health Care Quality says, "You want to provide the best quality product at the lowest price. Most people want affordable, high-quality health care. And just like other markets, the people who can do that will be the winners. That's where analyzing processes, measuring outcomes, and changing practices come into play: Most doctors think they already deliver high-quality, affordable care. But if you don't measure it, you don't know it."

Medicare is trying to promote improvements through several programs that encourage physicians to track their quality activities and adopt technology. Driven by the Affordable Care Act, most of these programs steer away from payments based purely on the number of patients physicians see or tests and procedures they perform, and they add incentives and penalties based on cost and quality factors, such as better outcomes and patient adherence to recommended care.

According to Harold D. Miller, president and chief executive officer of the Center for Healthcare Quality and Payment Reform, "Achieving value also requires restructuring how health care is paid for. It's redesigning the way care is delivered and having payment that supports that design. That's value-based care: when the care delivery and the payment go hand in hand."

Some large private practices and organizations are attempting to better link the two with models like accountable care organizations (ACOs) and bundled payments. Miller adds, "One of today's challenges is trying to convince an employer to contract with you. The question often asked is: 'How do I know these are good doctors?' Everybody knows there are savings to be had, and value-based care is the direction [the system] is going. The question is whether it will be a good version or a bad version. Physicians need to stand up and say: We recognize there's an issue with spending and there's an issue with quality, and we are going to address it. But here's what we need to be able to do that. Physicians can and should bring solutions to the table that will work, and patients will be a whole lot happier."

What are the different Medicare physician quality reporting programs?

There are three main programs to which physicians report their quality data and a fourth under which Medicare uses that data to issue public "report cards" on physician quality. The programs are interconnected and Medicare now docks physicians' pay for failing to participate.

1. Under the Physician Quality Reporting System (PQRS), physicians must document and report on the care they provide through a set of clinical quality measures. There are now hundreds of measures to choose from. Over time, practices also must report on patient experience and satisfaction using Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

2. The meaningful use (MU) program requires physicians to demonstrate that they are using certified electronic health records (EHRs) to improve quality, safety, and efficiency in their practices. Compliance criteria increase over time over three stages that focus on data capture and sharing (Stage 1); advanced clinical processes (Stage 2); and improved outcomes (Stage 3).

3. In 2015, Medicare implemented the value-based payment modifier (VBM), which adjusts physician payments based on the quality data they report to PQRS and on Medicare cost data. Payments to large practices face adjustments this year based on 2013 quality and cost data, and 2015 reporting will determine payments for all physicians in 2017.

TMA Council on Health Care Quality member Michael Ragain, MD, also reminds physicians of the public element to quality reporting through Medicare's Physician Compare website. Meant to help inform patients looking for Medicare doctors, the website displays quality ratings derived from physicians' quality performance scores. "Uninformed consumers are going to look at that, and it's going to be a very inaccurate but well-publicized proxy for your quality if you are not scoring well," Dr. Ragain says.

How are these programs tied to quality?

Although no quality reporting program is perfect, physicians should decide for themselves the costs versus the potential benefits. Dr. Ragain adds, "But any time a physician can meaningfully reflect upon his or her own practice, actively consider ways to improve it, and have control over that process, that can be very useful. One advantage to Medicare's quality programs over commercial programs is with Medicare you get to choose, and you know ahead of time what those measures are. The disadvantage is the bureaucratic hassle, so it pays to plan ahead and understand exactly what the metric says."

Having the flexibility to choose measures also allows Dr. Ragain to develop a plan to boost disease screening and immunization rates. "In studies where you ask doctors if they believe in giving Pneumovax, 99% say yes, but only 20% or less are getting it. It's about systems, and like anything, if you set up a system to deliver that care, it works better than if you depend on individual memory." Dr. Ragain says. "Now we'll drive those rates high, and that will change care. Especially with the new quality and resource use reports (QRURs) Medicare released, knowing how we fare compared to the average range and benchmark is a good thing. And it's really the first time we actually had that kind of clinical data feedback."

The feedback reports provide information on physicians' cost and quality performance in 2013 and how they compare with their peers. Dr. Ragain says the analysis, though tricky to interpret, got his group thinking about how to coordinate specialty and primary care so patients who primarily visit the ophthalmology clinic, for example, don't miss their vaccinations.

Conclusion

Medicare's approach certainly has its flaws, and medicine continues to advocate for fixes that streamline the myriad administrative requirements and appropriately measure and value physician performance. In 2015, all three of Medicare's main physician quality reporting programs started penalizing practices for noncompliance, and penalties will grow in the future. At the same time, the programs were intended to give physicians clinical data to help them improve health outcomes, and Medicare finally released quality and cost reports that physicians should use to gauge how these value-based programs likely will impact their practices.

Physicians will have to do their own math to determine the cost of the programs versus the penalty of foregoing participation. Many physicians may not have the option not to participate based on their patient population, now that so many patients are covered by Medicare. So they definitely should pay attention. It will hurt financially — and by reputation — if they get a bad mark from Medicare on a quality report. But it won't be because great doctors aren't doing a great job, just that they are not putting the systems in place to manage it. **DMJ**

Want more information?

TMA's 2016 TexMed Quality track will present, "MACRAgeddon: A New Era in Quality." The CME event will be held on Saturday, April 30, 2016, 10:00 am – 1:30 pm. The program will describe the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) and its impact on quality and payment for practicing Medicare physicians. The program also will distinguish the differences between Medicare's new quality-focused payment models: Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Attendees also will be able to identify practice strategies to improve quality and value-based outcomes. For questions or to register call the TMA Knowledge Center at 800-880-7955 or e-mail knowledge@texmed.org.

Medicare's Alphabet Soup

PQRS — Physician Quality Reporting System
Medicare program requiring physicians to document and report on clinical quality measures. Scores feed into the VBM, value-based payment modifier (see below).

MU — Meaningful Use
Medicare's electronic health records incentive program.

VBM — Value-based Payment Modifier
Medicare calculation to adjust physician fee-for-service payments either up or down based on how they perform on cost and quality factors.

CAHPS — Consumer Assessment of Healthcare Providers and Systems
Patient satisfaction and experience surveys.

QRUR — Quality and Resource Use Report
Medicare feedback reports on physician quality and cost scores and how they compare to their peers.

SGR — Sustainable Growth Rate
Medicare formula to calculate physician fee-for-service payment rates.

MIPS — Merit-Based Incentive Payment System
Alternative value-based payment system proposed under draft SGR repeal legislation that combines these current programs: PQRS, MU, and VBM.

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