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Physician Wellness

Harry's Homilies©

Harry L.S. Knopf, MD

ON GENEROSITY

You cannot hide a generous heart

I am not sure whether you can learn to be generous or if it is born within you. Generosity seems to be a personality trait, like obsessive-compulsive behavior or anxiety, but more productive. Parents may nurture the behavior: A born-generous person will be even more generous if his/her parents set the example. And the trait is often exhibited early in childhood: kindness, helpfulness, good-natured spirit. It is hard to hide it! And it only grows stronger with time, even if circumstances do not allow its expression by means of money. I have seen many poor people contribute amounts much greater in proportion to their income than wealthier people with much more to give. Generosity is not always measured in dollars. Rather, it is heartfelt.

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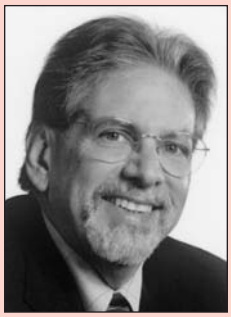
Dr. Knopf is editor of Harry's Homilies©. He is an ophthalmologist in private practice.

SCAM-Q*

** How insurance companies, hospitals, government, etc. Slice Costs And Maintain Quality*

Stick it Where the Sun Don't Shine

By Richard J. Gimpelson, MD



Richard J. Gimpelson, MD

How many of you have been told this or told this to someone else? Now this can be interpreted as an insult or merely the description of an important medical procedure, i.e., colonoscopy.

As for as colonoscopy, this procedure is very critical in the diagnosis and treatment of a number of causes of G.I. bleeding as well as screening for colorectal cancer.

Unfortunately, insurance companies are attempting to discontinue coverage of anesthesiologist-supervised sedation in endoscopy procedures. When Aetna announced that it would end this coverage as of April 1, 2008, it caused a furor among many gastroenterologists with some groups turning in letters of resignation, and in response, Aetna backed off its decision.

It should be noted that Humana discontinued this coverage last year and WellPoint did so in June 2006.

As physicians and hospitals continue to emphasize patient safety and access to care, it appears that this decision to eliminate anesthesiologists will increase potential complications as well as discourage some patients from getting colorectal cancer screening because of concerns about discomfort.

In speaking for the original decision to discontinue, James Cross, MD, Aetna's national head of medical policy and program administration, said Aetna encourages preventive screening, but believes it can better spend its money expanding the number of colonoscopies performed than paying for unnecessary services. I am puzzled how Aetna or any insurance company (including CMS) can declare any treatment or procedure medically unnecessary without first examining the patient. Isn't this practicing medicine without a license?

I wonder what procedures the insurance companies will refuse anesthesia coverage for in the future.

I have personally moved procedures that I previously performed in the office to the operating room and outpatient surgery center because insurance companies refused to pay for anesthesia given by the operating surgeon. I guess the gastroenterologist will assume the medical legal risk for giving anesthesia but not get reimbursed.

Yes, slicing costs and maintaining quality is the buzz word.

I know what many physicians would like to say to the insurance companies and CMS, but will it be interpreted as an insult or merely recommending a procedure done without anesthesiologist coverage?

■ ■ ■

Note: The source of this article is American Medical News (February 4, 2008).

Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.

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FEATURES

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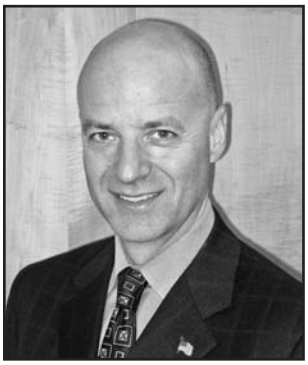
Pay for Performance: A Wolf in Sheep's Clothing

Ongoing input from organized medicine is essential



Medical Society President George J. Hruza, MD, MBA

Pay for performance (P4P) sounds so positive that, on its face, it would seem to be a great idea until one looks into its details. Outside of health care, P4P has been used primarily to reward employees with additional compensation who produce more widgets with the same resources, who increase revenue or profit or who reduce costs. In the health-care setting, P4P has been wrapped in the cloak of improved quality of care. Unfortunately, most P4P plans in health care have focused on "efficiency" due to the relative ease of measuring the cost of care and the desire of third-party payers to reduce costs. Quality is repeatedly mentioned, but rarely found when the plan details are analyzed closely.

The AMA has proposed five principles for P4P plans: 1) ensure quality of care, 2) foster the patient/physicians relationship, 3) offer voluntary physician participation, 4) use accurate data and fair reporting and 5) provide fair and equitable program incentives. These are good benchmarks to measure P4P plans against. Are there any plans that meet the AMA criteria? I am not aware of any.

> **"There are a number of actions we as physicians can take to influence P4P for the better as P4P is not going away any time soon."**

There are a few programs that have focused on quality. In the British National Health Service, 8,000 primary-care doctors agreed to receive bonus payments according to their performance on 146 quality indicators. Funding for primary care was increased by 20% allowing the practices to invest in extra staff and technology. The program has been a success with 97% of quality measures being achieved by the doctors who earned an average of $40,000 more under the program. This shows that quality can be improved, but at significantly increased costs.

In the U.S., with few exceptions, the record of P4P is a lot less encouraging. CMS has taken, at the prodding of Congress, a few baby steps into P4P. Currently physicians may be eligible for a 1.5% bonus if they report on certain specialty-specific quality measures. For most practices, such minimal financial incentives are not worth the added administrative burden. Going forward, in order to get a piece of this "generous" incentive, practices will have to invest $$$ into electronic health records (EHR) systems without any support from CMS.

Lacking national standards in quality measures, insurance companies are developing their own proprietary P4P plans. A couple of years ago, United Healthcare imposed a "P4P" plan in St. Louis without local physician input. Patients were penalized with increased co-pays if they saw a network physician who was not on the preferred list. The physicians with a gold star were picked based on proprietary measures that seemed to focus on low cost rather than quality. With strong opposition from SLMMS, local physicians and hospital systems, the P4P plan was scrapped and UHC went back to the drawing board. They have developed, with local physician input, a number of quality measures in most specialties that could be gleaned from claims data. The tricky part was separating measures that are under the control of the physician from those under the control of the patient. How this new P4P plan will be implemented remains to be seen. Outside of the St. Louis area, UHC has introduced a P4P plan that gives one star to physicians who meet proprietary P4P quality measures and

two stars to those from the first group, who provide care at the lowest cost.

Now imagine that each managed care plan you participate with designs its own P4P plan with proprietary quality and efficiency measures. A physician would have to tailor care for a given patient based on what managed-care company the patient has. I strongly believe that patient care should be based on individual patient needs and not on insurance company mandates. In addition, the administrative hassles implicit in keeping track of dozens of different P4P plans would make it prohibitively expensive and impractical even with an EHR in place. Finally, practicing according to proprietary or even standardized algorithms eliminates the "art" of medicine and stifles innovation.

P4P is still in its infancy, but it is already clear that without significant physician input, these plans are not beneficial for the patient-physician relationship. There are a number of actions we as physicians can take to influence P4P for the better as P4P is not going away any time soon.

- First, learn what quality and cost-containment measures the plan will be using. Request a detailed explanation of the specialty-specific measures that you will be expected to meet.
- Second, develop the necessary administrative procedures to capture and report on the measures to the managed care organization. Even if the P4P plan is based purely on claims data, it is important to track the measures within your office to make sure that you are meeting the metrics. This way, if you are subsequently penalized for not meeting the P4P measures, you will have ammunition to challenge the managed care company determination.
- Finally, train your staff to correctly document and report on the P4P measures. In most cases, it just means that the CPT and ICD-9 coding report reflects what has been done for the patient.

If you are put in the non-preferred portion of the network, you should find out if the determination is valid and challenge it. Review your contract to see if the plan is allowed to set up tiers of physicians and what appeal rights you may have. Get a copy of your individual profile from the insurance company and review it for accuracy and completeness. If your practice variation from the norm is correctly documented, figure out if the data is correctly adjusted for complexity of cases you treat and if your patients are sicker than average. Are you compared to peers in your specialty? Is the number of cases used for your rating sufficient to provide valid information? If you find that the data in your profile is inaccurate or the methodology flawed, file a formal appeal with the insurance company. If you do not receive satisfaction with them, file a complaint with the insurance commissioner and SLMMS Physician Grievance Committee.

SLMMS and organized medicine need to be on the lookout for flawed P4P plans. We should work with insurers to make sure that these plans do not harm patient care and focus on patient quality rather than trying to provide care for the lowest cost. If flawed P4P plans are introduced over our objections, we need to educate patients, employers, legislators, regulators and the public about plans that may have a negative effect on the care they receive. We should encourage patients and employers to vote with their wallets, legislators to provide legislative relief and regulators to protect patients.

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From the Executive Vice President

Circle The Wagons!

Physicians are besieged on many sides

Medical Society Executive Vice President Thomas A. Watters, CAE

There may never be a more important time to be a member of organized medicine. There may never be a better way a physician could spend his or her money than by supporting organized medicine. There may never again be as good a chance as there is today to positively influence the future of the medical profession.

Physicians are besieged on all sides. I wish I were an editorial cartoonist so I could draw an overly simplistic graphic representation of a few doctors hiding within a circle of covered wagons, threatened from all sides by various foes on horseback representing an assortment of diverse threats. Psychologists wanting to prescribe drugs, including controlled substances. Lay midwives wanting to deliver babies without proper education, licensing, supervision or insurance. Advanced practice nurses wanting to prescribe all but Schedule I controlled substances. Pharmacists wanting to change the prescriptions you write.

And all the threats aren't from individuals. Some are from groups, and companies. Imaging centers want to report direct to patients without reporting first to you, the managing physician. Pharmacies and grocery stores want to practice medicine in loose collaborative agreements that are basically unsound. Insurance companies (assuming they know more about the practice of medicine than physicians) want to tell doctors what anesthesia they may and may not use with certain procedures – endoscopies for example – putting cost savings for their companies ahead of patient convenience and plain old good medicine. Health plan providers now include so-called "most favored nation" clauses in your contracts.

Apart from private threats, the government is always circling, looking for a weak spot or gap between the wagons. The federal government is ready to dictate to doctors the technology and procedures they must use to keep patient records and require they spend the necessary money. Medicare threatens year after year to cut payments, while at the same time never keeps up with inflation. State budgets seldom keep pace and payments continue to lose traction against the rising inflationary costs to physicians. Government agencies, insurance companies and business consortiums continue to attempt to dictate pay for performance plans based more on price than on quality.

I could go on, but I think I've made my point. These are all real issues, and are all current problems – problems that exist right now. And they're all problems that your Medical Society has dealt with recently and continues to deal with today. As EVP of your Medical Society, I see on a day-to-day basis the constant onslaught from many diverse threats which all have one common denominator. Everyone wants to either do your job, or tell you <u>how</u> to do your job, without going to medical school.

> **"We're surrounded by the federal government, state governments, insurance companies, health care consortiums, and other professionals, lobbyists and groups of all shapes and sizes threatening to tell you how to practice medicine, or expand their scope of practice farther and farther into your realm."**

My position here with SLMMS sometimes makes a familiar tune ring in my head -- that song from the 70s, "Stuck in the Middle With You" by Stealers Wheel. And no wonder. We're surrounded by the federal government, state governments, insurance companies, health care consortiums, and other professionals, lobbyists and groups of all shapes and sizes threat-

continued on page 8

Circle the Wagons *(continued)*

ening to tell you how to practice medicine, or expand their scope of practice farther and farther into your realm. And they're relentless – they simultaneously poke and probe at every weak spot in organized medicine on a daily basis. Protecting your turf has never been more important.

"Protecting your turf" is a term that often has a negative ring to it. But in this case, we're not talking about selfish protectionism; more important, we're talking about your patients' best interests. And it's a cause that requires some time and attention from each of you.

Recently we put out an urgent call for a couple of physicians to testify against the new legislation that has moved successfully through the state Senate and is now in the House. It will give advanced practice nurses greatly enhanced authority to write prescriptions for controlled substances. We believe this is not in patients' best interests. We also believe it is not in your best interests. In such cases, physician testimony is critical. When that doesn't happen, the legislators hear only one side, and assume because no physicians appear with anything negative to say about it, the legislation must be okay. Unfortunately, we here at SLMMS were unable to come up with even one physician to testify. Fortunately there were a few physicians from around the state who testified, but not as many as we needed, and that legislation is now moving ahead with growing potential for passage.

Every physician has a role to play in organized medicine. It is no stronger than its individual pieces. The Society's role is to put those pieces into play. Having more of your direct e-mail addresses would help us do our job more effectively. Recently we sent out nearly 500 e-mails to members in an attempt to find physicians to testify. It sounds like a lot, but our e-mail glass is only one-third full. It means there are still about a thousand of you who did not receive the call because we didn't have your e-mail address. Help us help you. Send me a quick e-mail with your personal e-mail address so we can add it to our database, or simply call our receptionist and give it to her. We're confident more of you want to get in the game.

Having said all that, we know that our members are busier practicing medicine than they've ever been. That's why we're here, and that's why we'll continue to circle the wagons on a regular basis and defend your right to practice medicine untethered and your patients' rights to receive competent treatment from qualified physicians. We accomplish small things every day, and occasionally have big victories, but the work goes on and the challenge remains constant and unyielding. That's why your Medical Society is so important to you, and with your continued support and involvement, we will continue to work on your behalf.

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Key Legislative Issues to Watch in 2008

Following are important bills affecting the practice of medicine which have been active in this session of the Missouri Legislature. Please consult MSMA Legislative Report for further updates and MSMA positions. Contact your local senator and representative to make your opinion heard on these issues.

Medicaid Physician Fees: A House committee approved an appropriation that would boost MO HealthNet (Medicaid) physician fees to over 65% of Medicare rates. Approval by the full House and Senate still required.

Nurse Prescribing: Would allow advanced practice nurses to prescribe controlled substances. Approved by the Senate. (SB 724) (HB 1620)

HPV Vaccine: The Senate approved a bill that would require the state to inform parents of sixth-grade girls about vaccines against the human papilloma virus. (SB 778)

Psychologists Prescribing: Would allow psychologists to prescribe drugs including controlled substances. (SB 917) (HB 1739)

Midwifery: Legalizes lay midwifery. Approved by Senate committee. (SB 1021)

Emergency Services for STEMI and Stroke: Would establish a coordinated emergency services system for victims of STEMI and stroke as is currently available to victims of trauma. (HB 1790 SB 1233)

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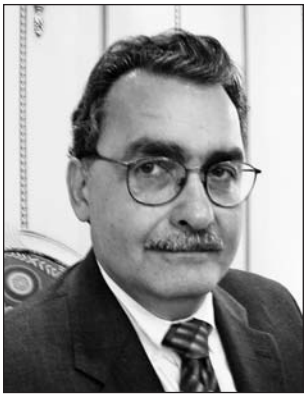
FEATURE

"We're Here to Help"

Missouri Physicians Health Program coordinates assistance for physicians suffering from practice-threatening impairments

By Jim Braibish



Bob Bondurant

An otherwise talented physician can lose his or her career, license and family due to substance abuse, alcoholism and other impairments. Or the physician may display inappropriate behaviors in the workplace that can be just as career-threatening.

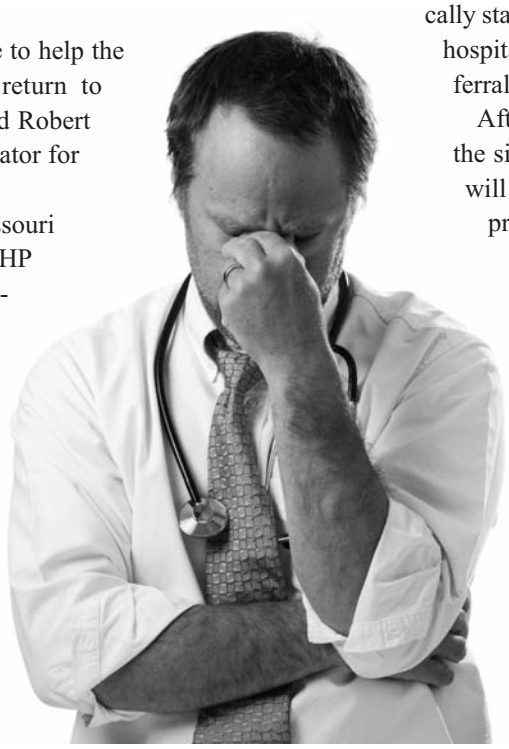
When such situations arise, the Missouri Physicians Health Program (MPHP) can help. The goal of MPHP is to link the physician with the proper resources and assistance – before it is too late.

"We provide a compassionate response to help the physician deal with the problem and return to healthy and professional functioning, said Robert Bondurant, RN, LCSW, program coordinator for MPHP.

Since its start in 1985 through the Missouri State Medical Association (MSMA), MPHP has helped hundreds of physicians overcome their impairments and resume practice. The program reports a 90% success rate. Serving physicians throughout the state, MPHP is a nonprofit corporation affiliated with MSMA.

Participation in MPHP as a client is voluntary and confidential. About 120 physicians are currently enrolled in the program, which includes a five-year follow-up period to assure that the impairment does not resurface.

> **"MPHP has helped hundreds of physicians overcome their impairments and resume practice. The program reports a 90% success rate."**



Getting Help

The sooner an intervention takes place, the better. "As a problem progresses further, the consequences worsen. These can include public exposure, disciplinary action of licensure boards, or loss of family relationships, financial resources and clinical privileges," Bondurant said.

About 60 percent of MPHP's clients enroll due to alcohol and drug abuse. Another 40 percent suffer from mental illness, sexual boundary issues or disruptive behaviors, Bondurant said. Examples of disruptive behaviors include intimidation, threats, hostility and verbal or even physical abuse. In addition, a physician might use the program to help deal with family issues such as problem children.

MPHP involvement typically starts with a call to the program from a colleague, hospital medical director, or spouse. About 24-30 referrals per year are received.

After the call, MPHP will attempt to learn about the situation through voluntary sources. A meeting will be arranged to confront the situation with the problem physician.

"We will say to the physician, 'We're worried about you and care for you. We're here to help you get help,'" Bondurant said.

Once in the program, the physician is connected with whatever services are needed, whether they be substance abuse treatment, counseling, mental health assistance or others. MPHP does not provide treatment itself, but serves as the case manager and coordinator connecting the physician with service providers around the country.

Participants agree to a five-year monitoring period to guard against relapse.

MPHP also can act as an advocate for the physician with regulatory and licensing agencies and with employers. MPHP in particular works with the Missouri State Board of Healing Arts to intervene with problem physicians before issues become irreparable, and meet requirements to resume licensing.

Educating the Medical Community

MPHP also provides education about impairment and disruptive physician issues, to help physicians and colleagues learn to identify and prevent problems. Bondurant regularly gives presentations to physician groups, hospital staffs and medical schools statewide.

Besides Bondurant, other MPHP staff members include medical director Jack Croughan, MD, along with a team of part-time contract intervention professionals located throughout the state. The agency's services are funded through participant fees, MSMA support, and contributions from hospitals and their medical staff.

Bondurant is passionate about MPHP's work. "Because of what we do, we have helped hundreds of physicians who today are providing service to thousands of patients."

If you suspect that you, a colleague, a friend or a relative is impaired, call the MPHP confidential hotline at 800-274-0933. In St. Louis, call (314) 995-4990. All communications are kept strictly confidential.

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Warning Signs

Following are signs of impaired and disruptive behavior. If you know of someone who displays multiple signs, it may be time to seek intervention. The sooner intervention takes place, the less damage may be done and the greater the chances for successful recovery.

Impaired Physician

- Smells of alcohol
- Disheveled appearance
- Excessive absenteeism or tardiness
- Behind in charting
- Suddenly unreliable
- Arrest

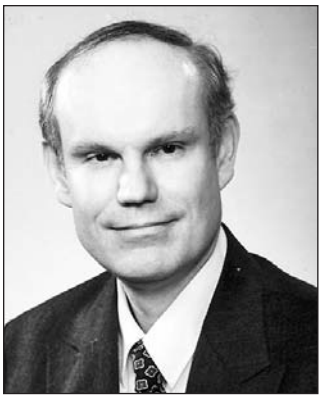
Disruptive Physician

- Threatening or abusive language directed to others
- Degrading or demeaning comments regarding others
- Uses profanity or offensive language excessively
- Threatening or intimidating physical contact
- Staff refuses to work with the physician

Things I Never Learned in Residency

Achieving wellness involves many facets

By Robert A. Brennan, Jr., MD



Robert A. Brennan, Jr., MD

Physician wellness was one of those things I never learned in residency. Wellness covers the business of medicine and finance, balance, continuing education, malpractice, sleep, and God and religion.

As for the business of medicine, none of us signed up to be businessmen. All we really wanted to do was to take good care of our patients. Now we are forced to look at the bottom line. We have to see more and more patients just to meet our overhead and our personal expenses. As a result, some of us are equating our financial success with our worth as physicians. Our personal worth tends to be tied to our physician worth. We feel significant if we are being productive. Our self esteem is at stake. We need to step back and realize medicine is not a business. It is a vocation. "What kind of physicians do we want to be?" We cannot ignore the business aspects, but we cannot make them our sole purpose in medicine. Perhaps we may have to scale back our standard of living in order to practice medicine in a suitable fashion.

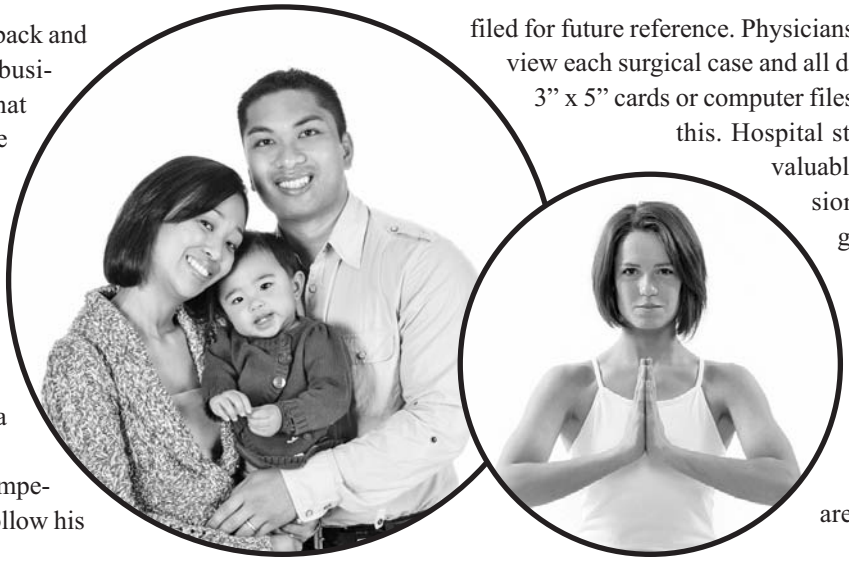
We need also to find a competent financial planner and follow his advice. Then we can focus on medicine, not the markets. A diversified portfolio, adequate insurance, asset protection, and savings are the cornerstones of financial security. The local medical society is a reliable referral source.

Outside Interests and Balance

As for balance in our lives, we all know what that means. It means taking time for family and friends. It means being there for special events. It means taking time for exercise and recreation. It means following the right diet and receiving regular medical check-ups. It also means finding outside interests besides medicine, although some of us are better at this than others. These outside interests are essential both now and in retirement. They also help us beat burnout. Our lives are more than just medicine. We are persons who happen to be physicians. Our family and friends appreciate more than just "the doctor."

> **"Our lives are more than just medicine. We are persons who happen to be physicians. Our family and friends appreciate more than just 'the doctor.'"**

Concerning continuing education, the cornerstone of all CMEs should be carefully selected journals that are regularly read and appropriately filed for future reference. Physicians should pre-evaluate and review each surgical case and all difficult medical cases. Using 3" x 5" cards or computer files are excellent ways of doing this. Hospital staff conferences are weekly valuable aids. In addition, brief sessions presented by local or regionally accessible teaching hospitals are usually worth considering rather than traveling longer distances for meetings. Consider the Internet as an excellent medical reference.



Wellness and malpractice are antitheses of each other.

The fear of a malpractice suit robs us of our peace and security. Fear of malpractice forces us to doubt our judgment and order more tests. It also causes us to limit our "high risk" procedures. As Dr. David Hilfiker says in his book, *Healing the Wounds*, "All of us who attempt to heal the wounds of others will ourselves be wounded." We must do our best and then stand! If a suit arises, we must consult with our insurance companies and with our lawyers. In addition, we must consult with other trusted colleagues and family members. However, care must be taken not to violate patient confidentiality. At the same time, we should not isolate ourselves and become depressed. Most physicians have been there. They can sympathize, empathize, and advise. The local medical society can also be of assistance.

Maintaining Rest and Peace

As for sleep, we all should try to have about eight hours per night. Dr. Roger Smith of the medical school at the University of Missouri-Kansas City says, "Fatigue is impairment." Lack of sleep affects our physical, our cognitive, and our psychological skills. Naps can help; however, there is no substitute for prolonged sleep. Maybe we should put off difficult surgical cases and procedures if we have been up all night. We can also limit our office patients. We could also consult our partners for help.

Finally, religion and God create wellness in our lives. A faith in God, whatever you conceive Him to be, creates faith in us. Stress and strain can be given to Someone else. The religious community also provides strength and solace. Books like *The Power of Positive Thinking* by Dr. Norman Vincent Peale and *Become a Better You* by Joel Osteen are also great sources of inspiration. How to *Stop Worrying and Start Living* by Dale Carnegie is another excellent book.

Many of these points may seem like common sense to most of us. Acting on them is a totally different thing, which I learned from being in private practice for more than 25 years.

These are the things that I never learned in residency.

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Robert A. Brennan, Jr., MD is an OB-GYN in private practice and secretary of the SLMMS Council. He coordinated the October 2007 SLMMS Physicians' Wellness Conference.