PENNSYLVANIA MEDICAL SOCIETY — THE POWERFUL VOICE FOR PHYSICIANS

pennsylvania PHYSICIAN

Winter 2018 | Volume 5 | Number 1

INNOVATION IN MEDICINE

Pennsylvania physicians lead innovation in health care across the nation.

p. 40

IN SAFE HANDS

Failsafe program prevents potential harm to patients and provides greater peace of mind.

p. 28

Help your Medicare patients

Medicare covers chronic care management (CCM) services

Improve care coordination for your Medicare patients with chronic conditions. The Centers for Medicare & Medicaid Services (CMS) has adopted separately billable codes to improve payment and access to CCM for Medicare beneficiaries with two or more chronic conditions. Health care professionals have an opportunity to be separately paid for important services while improving your Medicare patients' self-management, health outcomes, and patient satisfaction.

Get tools and resources to help you successfully implement and bill for CCM services at:

go.cms.gov/ccm

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Cover physicians left to right: Dimitri Papanagnou, MD; Theodore Christopher, MD, FACEP; Bon Ku, MD, MPP

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Theodore Christopher, MD, FACEP
President, PAMED

INNOVATION KEY TO THE FUTURE OF HEALTH CARE

Innovation in medicine is key to the future of health care. The never-ending journey to provide and improve patient care includes strengthening and expanding the roles of physicians to take the lead in delivering state-of-the-art, innovative medical care and proposing new health care delivery models.

Medical Student and Resident Education

It begins with a vastly different medical education of our students and residents. Medical schools like Jefferson are in the throes of curriculum and didactic changes like we've never seen before.

Flipped classrooms, case and problem-based learning, design-thinking and creativity, innovative online, just-in-time, simulation and experiential learning, IBM Watson, virtual care and teleconferencing are just some of the innovations that are occurring in our academic medical centers today. Learn more about innovations at Jefferson on page 40.

Innovative Tools in Health Care Delivery

Millennials — born between 1980 and 2006 and representing 25 percent of the population — are already expecting a new kind of on-demand health care delivery model. Like they do with Amazon and Netflix, they expect a top-notch consumer health care experience to be delivered to them, where and when they want it.

Telemedicine is one example of the many innovative tools now being used for delivering digitized health care. It is one of PAMED's advocacy priorities, and you can learn more at *www.pamedsoc.org/Advocacy.*

Women in Medicine

More than 50 percent of students entering the field of medicine are women, including my daughters. Women are undoubtedly going to play a key role in leading us into the future of medicine and health care delivery.

Learn more about PAMED's Women Physicians Caucus at *www.pamedsoc.org/WPC.*

These are interesting and exciting times to say the least. This coming year, I will walk with you, talk with you, and learn more from you. Together, we will address many of the issues that face physicians today.

Please join me in passionately preparing for how we all will be practicing medicine tomorrow, and defining the future of health care delivery. Without a doubt, that future is now in front of all of us.

Theodore Christopher, MD, FACEP
President, PAMED

PLEASE JOIN ME IN PASSIONATELY PREPARING FOR HOW WE ALL WILL BE PRACTICING MEDICINE TOMORROW.

Addendum

The Fall 2017 issue of the *Pennsylvania Physician* magazine (Volume 4, Number 3) included an article titled *Keeping Physicians Away from the Competition.* The article addressed the use of restrictive covenants in physician contracts. PAMED's policy regarding restrictive covenants, however, was not included in the article. PAMED opposes non-compete restrictive covenant provisions in physician contracts. PAMED also opposes the use of restrictive covenants as a condition for physicians entering into training programs. PAMED has been charged with seeking legislation prohibiting employers from requiring a physician from competing with the employer. This requirement would not preclude a buyout clause that requires the physician to reimburse the employer for reasonable expenses incurred in recruiting the physician and establishing the physician's patient base.

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PHYSICIAN

PENNSYLVANIA MEDICAL SOCIETY —
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INNOVATION IN MEDICINE — YOU DON'T HAVE TO FACE IT ALONE

PAMED's north star has always been the physician-patient relationship. Keeping that front of mind is what guides us to set priorities in the changing health care environment.

PAMED innovates its place in the world by advocating for you. We are your voice to ensure that emerging issues dealing with team-based care, telemedicine, prior authorization and credentialing, opioid abuse, and Pennsylvania Physician Orders for Life-Sustaining Treatment (POLST) are in the best interest of care for your patients and your practice. We go to the Hill to advocate for health care that emphasizes the best and timeliest patient care, with the least amount of barriers for physicians to deliver that care.

The Care Centered Collaborative has a new set of services available. Its new MSO programs are designed to help you assess and improve the financial health of your practice, adapt to changing risk-based payment programs, and increase productivity. These MSO capabilities include: Revenue Cycle Management, Patient Access support, and Practice Operations services. These services have been negotiated to a lower special rate for PAMED members.

Innovation in medicine is changing the way health care is delivered and practiced, and PAMED is keeping up to date. Every aspect of medicine needs to innovate to advance with the changing skills physicians need to thrive. We strive to keep you informed of those changes. You will find out more as we highlight information in our drive to define the physician of 2020.

Martin P. Raniowski, MA
Executive Vice President, PAMED

Don't face the challenges of practicing medicine alone. PAMED is here for you. If you're a member, contact us to help you with your practice, education, or advocacy needs.

I would like to thank each member for your support, and ask that you don't forget to renew your membership for 2018 at *www.pamedsoc.org/renew.*

If you are not a member, please consider joining us at *JoinNow.pamedsoc.org.* We are here to help you, too.

Martin P. Raniowski, MA
Executive Vice President, PAMED

4 Easy Steps to Meeting Your Licensure Requirements

The Pennsylvania Medical Society (PAMED) has you covered. Meet requirements conveniently, and on your own time!

Step 1 — Child Abuse Education

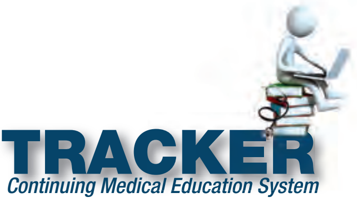
Take PAMED's online CME course to meet your child abuse recognition and reporting training requirement.

Step 2 — Opioids Education

Complete required education on pain management, addiction, or opioid prescribing if you prescribe or dispense controlled substances. PAMED has several activities to choose from.

Step 3 — Patient Safety and Risk Management CME

Get the 12 credits of patient safety and risk management CME you need with PAMED's online courses.



Step 4 — Track Your Progress

Enter your CME activity using PAMED's Tracker software. It's an easy way to figure out if you've met your 100 hours of CME requirement.

Find free and discounted CME, FAQs on license renewal, and more at www.pamedsoc.org/CME.

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We’ve joined Penn State Health!

Cocoa Family Medicine

Cornerstone Family Health Associates

Diabetes Center for Improvement

Eastbrook Family Health Center

General Internal Medicine

Kissel Hill Family Care

Lancaster Hematology Oncology Care

Manor Family Health Center

Mountville Family Practice Associates

Oyster Point Family Health

PAL South Family Medicine

Physicians’ Alliance LTD Lab

Red Rose Pediatrics

White Rose Family

Still here for you, we are inspired to continue making a difference in the health and well being of people in our community.

PennState Health inspired together

Pennsylvania Physicians Tackle Informed Consent, Scope of Practice, and More at 2017 PAMED

House of Delegates

More than 200 physician and medical student delegates met at the 2017 House of Delegates — held Oct. 13-15, 2017, in Hershey — to debate many of the biggest current and emerging issues affecting Pennsylvania health care today.

During the meeting, delegates representing counties, specialties, and member sections addressed avenues for fixing the process for obtaining informed consent in Pennsylvania, reaffirmed PAMED's support for physician-led, team-based care, and proposed solutions for numerous public health issues.

Resolutions addressed these main topic areas:

» **Health Care Legislation and Regulations,** including topics such as informed consent, scope of practice, hospital privileges, and opposition to mandated clinical guidelines

» **Public Health and Education,** including topics such as medication-assisted treatment for substance use disorders, safe sleeping environments for Pennsylvania infants, and disparity in access to care for female veterans

» **Practice Issues and Reimbursement,** including topics such as air ambulance regulations, the Direct Primary Care practice model, and access to care

Physicians also discussed ways to enhance the PAMED member experience, such as improving transparency, finding new ways to engage members, and more.

Get a recap of the resolutions adopted or referred to the PAMED Board of Trustees for study/decision at *www.pamedsoc.org/HODRecap.*

PAMED thanks the physician and medical student leaders who attended the 2017 House of Delegates and Annual Education Conference. Your engaged and thoughtful debate helped make this annual event a success.

A delegate steps up to the mic to debate an important issue on the floor of the House.

Delegates listen and testify during reference committee hearings.

Theodore (Ted) Christopher, MD, FACEP, is sworn in as PAMED's 168th president, with his daughters by his side.

Women delegates with PAMED's Women Physicians Caucus (WPC) Chair Sherry Blumenthal, MD, at the WPC Social and Networking Meeting.

Save the date for the 2018 House of Delegates and Annual Education Conference, which will be held Oct. 26-28, 2018, in Hershey.

Nearly 200 physician and medical student delegates ready to discuss and debate important issues affecting Pennsylvania medicine on the floor of the House.

Outgoing PAMED President Charles Cutler, MD, with Outgoing Board Chair David Talenti, MD.

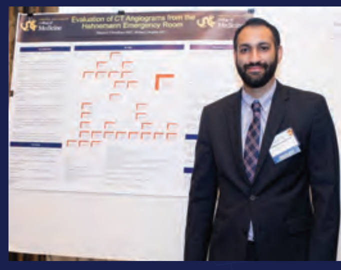
PAMED's residents, fellows, and medical students had the opportunity to participate in section-specific events during PAMED's 2017 House of Delegates and Annual Education Conference.

Residents & Fellows Poster Competition

Four members of PAMED's Residents and Fellows Section (RFS) took home cash prizes at the section's annual poster competition held Oct. 14, 2017, in Hershey.

"I had a great experience during the delegate meeting being a part of the Philadelphia County and Residents and Fellows delegation," said first-place winner Ekamjeet Randhawa, MD. "I enjoyed the chance to collaborate with physicians and medical students from around the state toward the betterment of our society."

The 2017 winners:



1st Place:
Ekamjeet Randhawa, MD

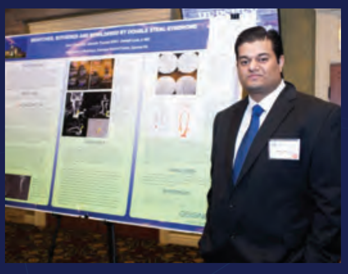
Drexel/Hahnemann, Philadelphia

Poster Title: *Evaluation of CT Angiograms from the Hahnemann Emergency Room*

2nd Place:
Divya Akella, MD

Crozer-Chester Medical Center, Chester

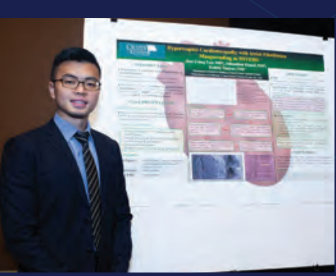
Poster Title: *Retrospective Analysis of Computed Tomography Angiography-Chest (CTA) for Pulmonary Embolism*



3rd Place:
Umar Tariq, MD

Geisinger Medical Center, Danville

Poster Title: *Thief in the Night: A Rare Case of Double Steal Syndrome*



Crowd Pleaser:
Jian Liang Tan, MD

Crozer-Chester Medical Center, Chester

Poster Title: *Hypertrophic Cardiomyopathy with Atrial Fibrillation Masquerading as STEMI*

There were 18 presenters at the 2017 RFS poster contest, and 26 member physicians helped judge the posters.

Medical Students Section Poster Contest & Debates

PAMED's Medical Students Section (MSS) held its first-ever student poster presentation on Oct. 13, 2017. Students from across the state submitted abstracts, and from them, 10 student posters were chosen to present at the annual meeting.

The 2017 winners were:

1st Place: Alex Adams

Sidney Kimmel Medical College at Thomas Jefferson University

Poster Title: *Opioid Overprescribing following Common Hand Surgeries*

2nd Place: Michael Loesche

Perelman School of Medicine at the University of Pennsylvania

Poster Title: *Temporal Stability in Chronic Wound Microbiota is Associated with Poor Healing*

3rd Place: Sachin Gandhi

Drexel University College of Medicine

Poster Title: *Assessing the Efficacy of CyberKnife Partial Breast Irradiation in the Community Care Setting*

Medical student members debate hot topics at PAMED's Medical Students Section 2nd annual Medical Students Debate.

"It was a phenomenal experience to present our team's research on national opioid prescribing practices after common hand surgeries at Pennsylvania Medical Society's Medical Student Poster Session this October [2017], and I am honored and very grateful to have received first prize in the competition," said poster contest winner Alex Adams.

Medical students also debated several health care hot topics at their second annual Medical Student Debates on Oct. 14, 2017, including insurance coverage, access to care, and physicians' aid in dying for terminally ill patients.

"The topics were really engaging, and I felt all the participants did an incredible job representing their positions," said debate moderator Matt Hope, a medical student at Geisinger Commonwealth School of Medicine. "These are important conversations to be had, and I hope the audience felt they got something out of the event!"

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Opioid Abuse Education Required for Physicians: *PAMED Has You Covered!*

Pennsylvania dispensers or prescribers applying for an initial license and those applying for re-licensure are required to complete opioid continuing education.

No Opioids Education = No License!

The Pennsylvania Medical Society (PAMED) has physicians covered with opioid-related online CME courses to help you meet licensure requirements. Access the CME at www.pamedsoc.org/OpioidsCME.

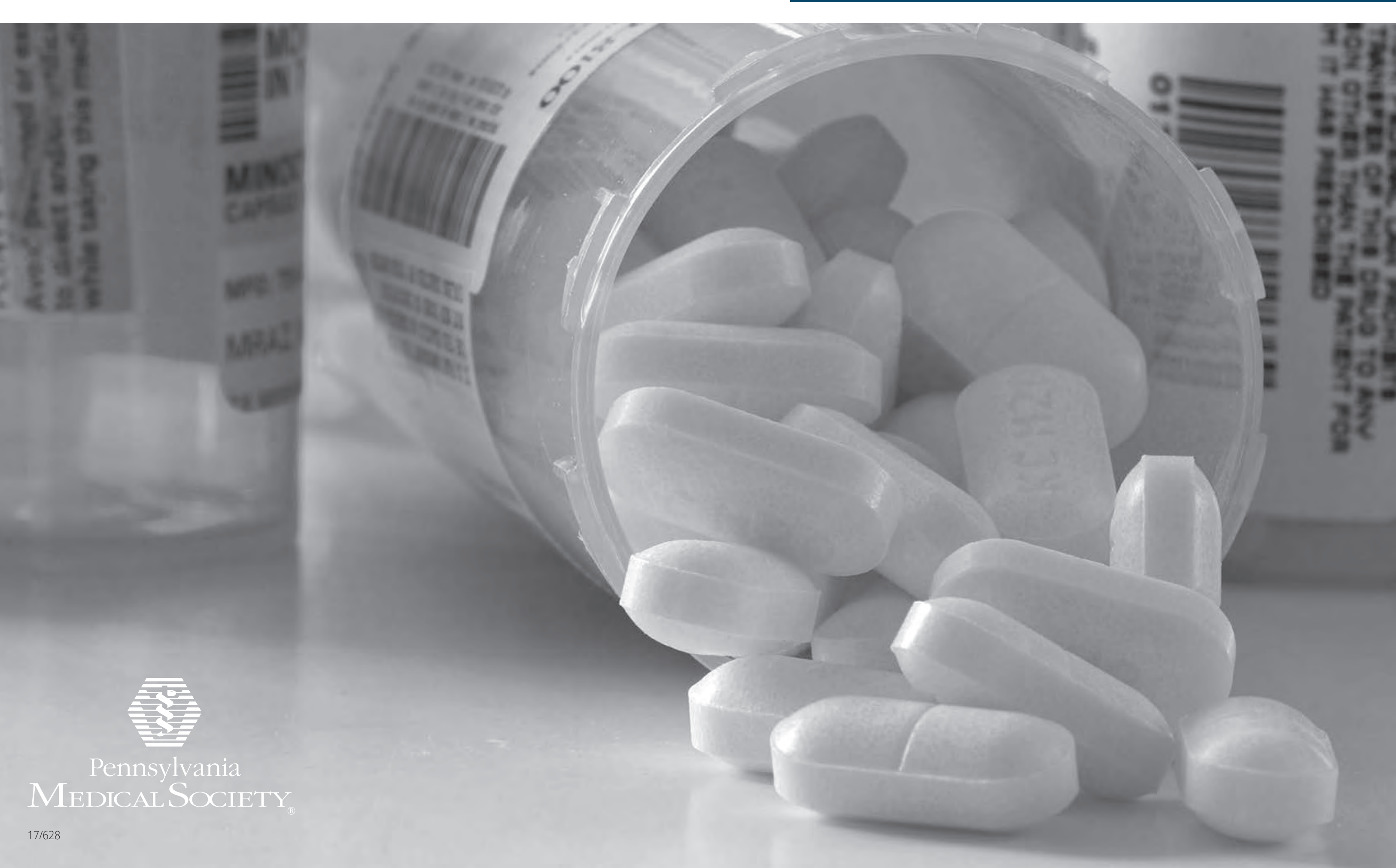
Physicians seeking initial licensure — Need two hours of education in pain management or identification of addiction AND at least two hours of education in the practices of prescribing of opioids (within 12 months of licensure).

Physicians seeking re-licensure — Need two hours of education in pain management, identification of addiction, or the practices of prescribing of opioids.

Access additional opioid-related resources at **www.pamedsoc.org/OpioidResources**.

Not yet a member? Join online at **www.pamedsoc.org/Join**. You may be eligible for $95 dues.

Questions? Contact PAMED's Knowledge Center at **855-PAMED4U (855-726-3348)** or **KnowledgeCenter@pamedsoc.org**.



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ALL PHYSICIANS ARE VITAL TO EMERGENCY PREPAREDNESS

BY DOUGLAS F. KUPAS, MD, FAEMS, FACEP

Las Vegas, Charlottesville, New York City, Boston ... Our world has changed dramatically in the last 17 years, and we now live with a constant threat in our schools, streets, movie theaters, and outdoor events.

We expect that physicians specializing in EMS, emergency medicine, trauma surgery, and critical care medicine are part of our hospital preparedness and mass casualty incident (MCI) planning, and nearly every member of a hospital staff is included in the plans for an MCI.

Beyond that, all physicians have special skills and a moral duty to be prepared, to help prepare the public, and to react to violence and injury in our communities.

In October 2015, the White House began the *Stop the Bleed* campaign to teach bleeding control to the public. *Stop the Bleed* is supported by Homeland Security, the American College of Surgeons, the American College of Emergency Physicians, and other physician organizations.

Stop the Bleed endeavors to teach lay providers, medical professionals, and first responders the most recent strategies to stop serious bleeding and to save lives.

You may have already seen *Stop the Bleed* kits hanging next to AEDs in airports or shopping malls. Whether used in a hostile event (like a shooting or bombing) or for an individual who puts an arm through a plate glass window, everyone should have the skills to stop bleeding.

A recent report from the National Academy of Sciences suggests that we should aim for "zero preventable deaths from injury," yet in Pennsylvania, people still die from external bleeding that can be controlled with simple techniques.

Stop the Bleed courses are short and include hands-on skills sessions. The courses focus on:

1. Use of tourniquets without hesitation for severe bleeding from an extremity. Commercial tourniquets are included in *Stop the Bleed* kits, and we should all know how to use them.
2. Packing of other seriously bleeding wounds and then application of direct pressure. Packing with sterile dressing impregnated with a hemostatic agent is ideal, but any clean cloth at hand is also fine. Wound packing to control bleeding is a relatively new concept in first aid skills. Direct pressure over the packed wound is important.

Recent events have shown the need for military-style bleeding control in our communities, and all physicians should know these skills for the same reasons that all physicians should be able and willing to start chest compressions/CPR for cardiac arrest. Health care workers are the most helpful medical immediate responders in our communities.

Severe bleeding and cardiac arrest are immediately life-threatening, and many individuals die from these before EMS can arrive. Bystander physicians are important immediate responders who can save lives through *Stop the Bleed* and CPR training. Get *Stop the Bleed* training now, and participate with your hospital/health system in National *Stop the Bleed* Day activities on March 31, 2018, and beyond.

Dr. Kupas is board certified in EMS and emergency medicine. He is an EMS physician, emergency physician, and director of Resuscitation Programs for Geisinger in Danville. Dr. Kupas serves as the EMS medical director at the Bloomsburg Fair, and volunteered as a physician EMS medical director at the 2017 National Boy Scout Jamboree.

HELPING YOU FOCUS ON WHAT YOU DO BEST - *CARE FOR YOUR PATIENTS*

Healthcare is past the tipping point. The shift from volume to value will continue to accelerate.

The Care Centered Collaborative was created specifically to assist Pennsylvania physicians with the transition to value-based care.

By offering MIPS reporting solutions, MSO services, Clinical Integration Network (CIN) development and resources, the Care Centered Collaborative is here to assist physicians remain independent and sustainable.

We Can Help You Today.

PAMED physicians receive a discount on all services.

*To learn more visit **patientccc.com** or call 570-702-1152*

Global Teen Health Week is an annual week-long designation to raise the profile of adolescent health. Health behaviors resulting in illness later in life often start in the teen years. Global Teen Health Week is unique in that it focuses on a holistic view of teen health.

Schools and organizations working with adolescents can celebrate any aspect of teen health. Activities can be as big or small as determined by the school community. During the week, activities should focus around themes which encompass most adolescent health issues:

Sun, March 18 — Violence Prevention
Mon, March 19 — Preventive Care & Vaccines
Tues, March 20 — Healthy Diet and Exercise
Wed, March 21 — Mental Health
Thurs, March 22 — Sexual Development & Health
Fri, March 23 — Substance Use & Abuse
Sat, March 24 — Oral Health

Behaviors of young people are influenced by friends, family, schools, community, and society. Teens are agents of change and Teen Health Week involves them in discussions that can positively affect their well-being and influence health behaviors in other teens, their families, and communities.

Join us in supporting #2018teenhealth globally!

Web: http://teenhealthweek.org/
Official color: lime green
#2018teenhealth

WHAT INNOVATION IN MEDICINE IS GOING TO MAKE THE MOST IMPACT ON YOUR CAREER IN THE NEXT FIVE YEARS?

We asked members of PAMED's sections about medical advancement and how it will affect their practice. Here's what they told us.

Andrew Lutzkanin, MD

EARLY CAREER PHYSICIAN PERSPECTIVE

ANDREW LUTZKANIN, MD

FAMILY MEDICINE
PENN STATE HERSHEY MEDICAL GROUP, MIDDLETOWN

CHAIR
PAMED EARLY CAREER PHYSICIANS SECTION

"Over the past year, PAMED has been making a large push toward attracting new members, particularly those early in their career or new to practice in Pennsylvania. To this end, the Early Career Physicians Section (ECPS) has had several focus group meetings trying to identify new and innovative ways of engaging our current members so they can, in turn, go out and help us recruit their peers.

The PAMED Board has also approved the creation of the Membership 2020 Task Force to look at the issue of recruiting new members and has taken a new approach: rather than having the task force comprised of current leadership, they have instead reached out to younger members to encourage their engagement.

As the vice chair and chair of the ECPS, respectively, Aaron George, DO, and I will be serving on the committee; our very own ECPS Trustee John M. Vasudevan, MD, of the Task Force, will be serving as chair. I am excited to see what this new group of folks comes up with and how we can have PAMED lead the way in new and innovative methods of reaching young physicians across Pennsylvania."

Gillian Naro

MEDICAL STUDENT PERSPECTIVE

GILLIAN NARO

PENN STATE COLLEGE OF MEDICINE, MS2

VICE CHAIR OF COMMITTEE ON BIOETHICS AND HUMANITIES, AND MEMBERSHIP CHAIR FOR REGION 6
AMA

AMA CHAPTER PRESIDENT AND PAMED SCHOOL DELEGATE
PENN STATE COLLEGE OF MEDICINE, HERSHEY

"Clinical teams continue to see a growing resistance to antibiotics, particularly in nosocomial infections. Antibiotic resistance has become a dangerous trend in medicine, rendering once-treatable infections life-threatening cases. Antimicrobial stewardship programs, designed to help care teams and infectious disease departments make responsible treatment choices, have been shown to be an effective and noble effort; however, new microbes with highly resistant strains continue to emerge.

Viruses called bacteriophages selectively infect specific bacteria species. They are among the most abundant species on the planet and naturally infect and kill bacteria in a highly specific manner. Innovative research is being done by the U.S. Navy to utilize bacteriophages' natural predatory role to treat antibiotic-resistant bacteria.

Using bacteriophages alongside antibiotics to treat bacterial infections offers effective treatment that can also alter bacteria, reverting antibiotic resistance in multi-drug-resistant cases. These bacteriophages have potential to be packaged on bandages, offering wound care and immediate prophylaxis against infection that could become systemic, or lead to amputation. Incorporation of bacteriophages can lead to a long-term reduction in the current trend of antibiotic-resistant bacterial strains."

Tani Malhotra, MD

RESIDENTS AND FELLOWS SECTION PERSPECTIVE

TANI MALHOTRA, MD

PGY-4, OBSTETRICS AND GYNECOLOGY
WELLSPAN YORK HOSPITAL

RESIDENTS AND FELLOWS SECTION TRUSTEE
PAMED BOARD

BOARD MEMBER
YORK COUNTY MEDICAL SOCIETY

VICE CHAIR
AMA-RFS REGION 6

"The consequences of the opioid epidemic fill the news on a nightly basis, and the death toll and economic costs continue to rise. As health care professionals, our focus needs to be forward-looking in finding solutions both for our patients and for the health of our communities. Since this opioid epidemic is not like anything we have dealt with before as doctors, health care providers, family members, or as a nation, simple answers do not exist and we need to find new, innovative ways to address the epidemic.

While opioid addiction is affecting people across all ages, races, and socio-economic statuses, the pregnant patients suffering from addiction tragically represent a double harm. Thankfully, Pennsylvania happens to be one of the 19 states across the U.S. that has treatment programs available to pregnant women. These programs are at risk of being overwhelmed by demand, and pregnant patients present unique medical and social challenges.

At York Hospital, we have developed a perinatal addiction committee that is an interdisciplinary work group that seeks to find solutions to common problems these women face. While there are several unresolved issues, having groups such as these offers different perspectives and innovative methods of approaching a problem that has been perplexing us as a nation. We must continue to seek such novel approaches and work toward ending this epidemic."

Shyam Sabat, MD

INTERNATIONAL MEDICAL GRADUATE PERSPECTIVE

SHYAM SABAT, MD

SECRETARY AND TREASURER
DAUPHIN COUNTY MEDICAL SOCIETY

AMA OMSS DELEGATE
PENN STATE HEALTH

ASSOCIATE PROFESSOR OF RADIOLOGY AND PROGRAM DIRECTOR FOR NEURORADIOLOGY ACGME FELLOWSHIP
PENN STATE MILTON S. HERSHEY MEDICAL CENTER, HERSHEY

"Change is inevitable. Virtually every industry is being changed by technology. Uber has disrupted the cab service, Amazon has revolutionized retail, and biotechnology has transformed the traditional pharma space. Disruption is fast approaching the shores of medicine, and we have to be on the right side to avoid being swept away.

I am a neuroradiologist, and radiology, by virtue of high technological presence, is one of the specialties most disrupted by artificial intelligence (AI). IBM Watson Health and Silicon Valley startups like Enlitic are analyzing billions of imaging to teach machines the correlation between image patterns and diseases. Deep learning (DL) techniques are being used to integrate epidemiological, clinical, and imaging data to develop algorithms that can detect lesions, diagnose them, generate differential diagnosis with probability numbers, suggest follow-up modalities and timings, and send reminders to patients and physicians.

AI has generated both fear as well as excitement in the radiology community. Some fear demise of the radiologist while others fear revenue sharing with AI systems and data overload. However, none of that is happening any time soon. Most likely, AI will serve as a very experienced virtual assistant, increasing workflow efficiency, increasing throughput, and giving access to information that otherwise would not have been available. And 10 years from now, radiologists/physicians won't imagine working without AI — just like the computer, Internet, cell phones, EMR, and PACS.

AI applications are already being tested for dermatology, pathology, internal medicine, orthopedics, and soon all specialties. AI is being touted as the next big frontier in medicine. It's best to be ready to join it rather than fight against it."

What Are PAMED's Sections?

Rapid, radical change faces the medical profession, but the younger generation — early career physicians, medical students, residents, and fellows — have the opportunity to shape their own futures. Similarly, the International Medical Graduate section brings together physicians with diverse backgrounds to share their concerns and experiences.

PAMED's sections for these diverse groups serve as their voices across the state. Members of the sections are engaged and involved in PAMED initiatives and policymaking.

PAMED's Sections:

Early Career Physicians Section (ECPS)

Residents and Fellows Section (RFS)

Medical Students Section (MSS)

International Medical Graduates Section (IMG)

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HOW PENNSYLVANIA HEALTH INFORMATION EXCHANGES ARE TRANSFORMING CARE COORDINATION

BY TARA GENSEMER

Coordination of care, closing care gaps, value-based payment models: How can a clinician address the ever-changing health care environment while decreasing overhead and maximizing efficiency?

A community of regional health information organizations (RHIOs) in Pennsylvania is ready to support the data-driven demands put upon clinicians and staff. RHIOs offer a solution — a Health Information Exchange (HIE) — which can streamline the process of information flow in and out of a practice.

An HIE can paint a more complete picture for patient care as well as reduce staff research time. By querying your HIE or simply receiving data directly into an integrated electronic health record (EHR), your practice could be receiving information such as medication lists; patient history; admission, discharge, and transfer (ADT) reports; or procedure notifications. Medical decision-making is supported with a more complete medical record, and a patient is spared additional time and money by avoiding redundant or duplicate procedures and testing.

One area where an HIE can help improve efficiency is transition of care management, which mandates patient follow-up 24 to 48 hours after discharge from a hospital or emergency department to reduce readmission rates.

"We are following up after every ADT, contacting every patient," says William Artz, DO, of Associated Family Practice Professionals, PC, and HealthShare Exchange participant. "Almost everyone comes in. Patients think it is awesome that we have that kind of access in order to care for them. We have had to change our workflow, setting aside a block of appointments, to capture patients discharged from the hospital and ED."

Additional benefits to participation in an HIE include the assistance in quality reporting. Patient queries could result in closing a gap in care, or indicate patient non-compliance. In some cases, locating information to close the gaps could be as easy as a few clicks of a mouse.

How Do I Get Started with an HIE?

Step one in HIE participation is asking questions. Here is a checklist that may be helpful when you are making decisions regarding your HIE:

What degree of collaboration does your HIE provide?

- Can it be integrated with my EHR?
- Is the HIE browser-based?

Does the HIE offer Direct Secure Messaging between providers?

What data is protected when I query the system?

- Would it include minors?
- Will it exchange sensitive information (super-protected information)?

Which exchange service providers are available in my area?

Talk with your service providers.

- Ask about sustainability.
- What are the internal requirements of your practice to participate in an exchange?
- Does the HIE have a dedicated team to support provider/practice training and education?
- Is marketing material and patient education provided?
- What are the fees associated with joining? Start up, monthly, annual?
- What are the risks and liability?
- What forms of exchange? FHIR or HL7?

Talk with your EHR vendor.

- What are the fees associated with integration?
- Do they offer interoperability?
- What is the estimated timeline of integration?
- Privacy and security?
- Maintenance fees?

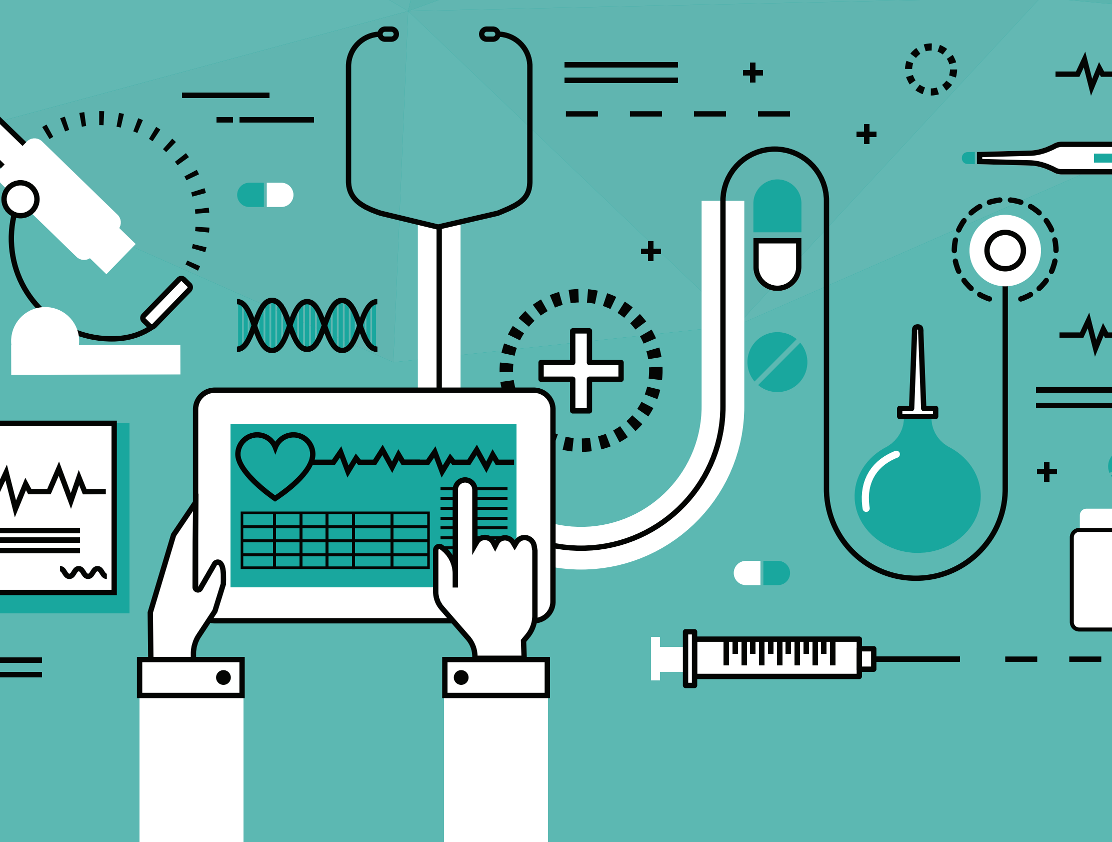
Participation in an HIE begins with support from your staff. As the HIE is integrated into your practice, staff will recognize workflow should be updated to reflect the use of the new tool. The exchange of electronic secure data will not only enable your practice to save time and money, but aid in satisfaction from patients and staff. Information received from an HIE data push or pull creates a longitudinal patient record readily available to interpret and improve treatment, provide solutions, and advance processes.

WHAT IS A Health Information Exchange?

An HIE is a secure exchange of health information between physicians, nurses, pharmacists, and other health care providers. HIEs aim to:

- Ensure continuity of care
- Avoid medical and medication errors
- Decrease duplicate procedures or testing
- Provide a complete medical record, verify medication, patient history
- Provide timely access to patient data
- Support patient safety
- Support physicians for unplanned care by helping them query the exchange for medication allergies, problem lists, and recent tests
- Reduce costs for your practice and patients

For more information regarding HIE, please visit *www.healthit.gov/HIE* or *dhs.pa.gov/provider/healthinformationexchange/*.



What Is Happening in Pennsylvania?

There are four regional health information organizations in Pennsylvania: HealthShare Exchange, ClinicalConnect HIE, Keystone Health Information Exchange, and Mount Nittany Exchange. The RHIOs coordinate with the Pennsylvania eHealth Partnership — the organization that maintains the Pennsylvania Patient and Provider Network (P3N) — to enable statewide health information exchange. P3N is considered the "hub" to allow secure health information to be exchanged between participating providers, the public health gateway, regional health information exchanges, care coordinators, and facilities across the state.

RHIOs work as a community, providing secure delivery of information to those who participate. It is a collaborative effort, notes Kim Chaundy, director of operations, Keystone Health Information Exchange. "We don't want to be an analytic tool; we want to feed into the tool to bring data together for the benefit of care coordination and workflow improvement opportunities. This is a key element RHIOs can offer," Chaundy says.

(continued on page 22)

HealthShare Exchange (HSX), incorporated as a nonprofit in 2012, services facilities and providers primarily in eastern Pennsylvania, specifically Greater Philadelphia, but is expanding its Exchange activities to South Jersey and other areas. The health information organization began its journey with Direct Secure Messaging, and now has more than 9,000 practitioners connected by its Provider Directory. It also has information on more than 5 million regional patients in its Clinical Data Repository (CDR), which provides longitudinal records of the recent medical history of these individuals.

HSX connects health plans and nearly all the hospitals and health systems (and their owned practices) in its service area, as well as behavioral health, long-term care, and Accountable Care Organizations (ACOs). More than 100 independent ambulatory practices are also included. It includes federal and city health clinics.

With emergency department and hospital admission data from its membership, HSX provides an Encounter Notification Service (ENS), which now includes more than 3 million patients, to alert members when their patients interface with a medical center anywhere in its region.

Martin Lupinetti, executive director, HSX, says, “There was a lack of information flow that needed to be addressed. A movement was started between hospitals and plans to find a better way.” HSX was built to aid providers in better care coordination and communication efforts, especially during transitions of care.

HSX’s CDR continues to grow, as more of its members also contribute Continuity of Care Documents (CCDs) in association with patient encounters. HSX has an implementation team that assists members in deploying its services, which are integrated whenever possible in the provider’s existing clinical workflow. The HIE provides 24/7 support and has a fee schedule based on organization type, patient volume, services selected, and other factors.

William Artz, DO

ClinicalConnect HIE services western Pennsylvania, spanning from Erie to the border of West Virginia and as far as Ohio to Muncy. The organization, which recently celebrated its fifth year of service, was founded by nine major hospitals in the Pittsburgh area that put competitiveness aside and collaborated on the project.

Today, ClinicalConnect HIE offers the longitudinal patient record, aggregating data from all member organizations. Additionally, ClinicalConnect HIE supplies data from its external trading partners using the federal and state data-sharing systems.

There are more than 3.2 million patients who are part of ClinicalConnect HIE. More than 1 million charts have been viewed using the Exchange. Direct Secure Messaging, a standard for exchanging clinical data through secure email, is also offered.

There are challenges with every HIE implementation, but ClinicalConnect HIE works to meet the HIE needs of participating providers with phased onboarding, flexible cost, and an experienced team. “Our goal is to see HIE incorporated as normal practice for clinical workflow,” says Laura Mosesso, outreach manager, ClinicalConnect HIE.

PATIENTS THINK IT IS AWESOME THAT WE HAVE THAT KIND OF ACCESS IN ORDER TO CARE FOR THEM.

Mount Nittany Exchange, based in State College, provides support for hospital systems, ambulatory practices, long-term care facilities, post-acute care centers, and free clinics, with an emphasis on small entities that do not have much in the way of IT support services.

To service clinicians who may not have the infrastructure to integrate an HIE into their day-to-day workflow, the Exchange offers a browser-based provider portal to close the gaps in the electronic continuum of care.

The Exchange also offers EHR integration for EHR systems that can consume Consolidated Clinical Document Architecture (CCD-A). CCD-A is the mandatory content used to create a CCD. A structured clinical document — typically sent through an HIE — will be delivered by CCD-A to provide patient data to a clinician querying the Exchange to coordinate patient care.

Mount Nittany Exchange transmits Direct Secure Messaging, allowing participating providers to send secure messages to other providers to communicate care coordination. The HIE also delivers a mobile app alert system, notifying providers of emergency department visits and inpatient admissions. Membership in this HIE is available to participants for a nominal fee. Delivery of training is web-based for those who are authorized to access patient data within the practice.

Keystone Health Information Exchange (KeyHIE) was established in 2005 and supports single physician practices, federally qualified health centers (FQHCs), critical access hospitals, and large health systems.

KeyHIE connects approximately 100 unique health care organizations, 26 hospitals, 335 physician practices, 29 home health agencies, 89 long-term care facilities, one pharmacy, four EMS services, and three insurance payers throughout Pennsylvania. This connectivity serves more than 5 million patients, across 53 counties, gathering data to provide a longitudinal medical record for care coordination and earlier treatment decisions by authorizing secure access across multiple platforms.

Recently, KeyHIE announced the availability of their Information Delivery Service (IDS). IDS provides a streamlined approach to delivering clinical information and pushes data directly to an EHR, where it will either be parsed to a holding tank for review or directly to a medical record, limiting staff research hours and maximizing efficiency. The RHIO has expanded its IDS to support a learning health system and value-based payments, including population health management, ACOs, and Bundled Payment Care Incentives (BPCIs).

Clients of KeyHIE can select from a basic package, which provides a browser-based clinical document viewer, to an advanced package that offers the clinical document viewer, plus Direct Secure Messaging, notifications and reminders, and EHR integration. All packages include MyKeyCare, a multi-facility patient portal that allows patients to access documents and lab results, request prescription renewals, and send secure messages to providers.

KeyHIE extends various training platforms that are tailored to the needs of staff, including customized workflows. Along with training, this HIE offers marketing tools, technical support, and a competitive fee schedule.

Investing in new technology can likely appear to be an expensive, laborious process. Each RHIO is prepared to aid a practice or facility to make that transition as seamless as possible, at a reasonable cost.

"We are all in the business of the dollar in many ways; an HIE pays for itself in less than a month," Dr. Artz points out. "We have had to reserve additional parking spaces to provide care based on the ability to capture patients coming out of the hospital from HIE notifications. Not only is this good for our business, it generates better patient care."

Tara Gensemer is a Practice Support Specialist on PAMED's Practice Support Team. Email her at *tgensemer@pamedsoc.org*.

Interested in Participating?

Here's who to contact:

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TELEMEDICINE NAMED A PAMED TOP LEGISLATIVE PRIORITY FOR 2018

For several years now, physicians across Pennsylvania and the country have grown increasingly reliant on the use of telemedicine technologies in the treatment of their patients. As such, PAMED is pursuing comprehensive telemedicine policy as one of its top legislative priorities.

For the scant few unfamiliar with the concept, telemedicine is the process by which medical diagnosis, consultation, and treatment are provided through live, interactive video and audio technology that connects physicians and patients who are in separate locations. This technology has proven particularly valuable for patients who reside in rural and remote areas of the commonwealth, urban communities that lack reliable transportation options, and for patients with significant mobility challenges that present a barrier to in-person consultations with physicians.

TECHNOLOGIES SUCH AS FACETIME, SKYPE, AND OTHERS CAN BE MORE THAN JUST A MEANS TO COMMUNICATE WITH FRIENDS AND FAMILY — THEY CAN BE VALUABLE EXTENSIONS OF A PHYSICIAN'S ABILITY TO CARE FOR PATIENTS.

While telemedicine has already proven to be a crucial tool for physicians ranging from dermatologists to psychiatrists, the technology has great promise and applicability in a variety of other specialties as well. As the number of medical services and applications for telemedicine continues to increase, PAMED, working in tandem with the Hospital and Healthsystem Association of Pennsylvania (HAP), understands that there is a clear need for a statutory framework under which telemedicine can continue to evolve.

While telemedicine services are being offered every day throughout the state, the process lacks important safeguards that only state law can provide. The bills, Senate Bill 780 and House Bill 1648, would establish a statutory definition for telemedicine, mandate that telemedicine services are reimbursed, and would prohibit "audio only" services (video must be available if either the patient or provider requests it). SB 780 was introduced by Sen. Elder Vogel, Jr. (R-Beaver, Lawrence, and Butler Counties), and HB 1648 was introduced by Rep. Marguerite Quinn (R-Bucks).

Though PAMED and HAP had originally pushed for payment parity between in-person encounters and services provided through telemedicine, support for such a provision in the legislation was non-existent and lacked support from our legislative sponsors. Nevertheless, PAMED and HAP continue to advocate for language that requires health insurers to reimburse providers for telemedicine services.

While adequate reimbursement is critical to further advancements in telemedicine technologies, concerns about the quality of care provided through this portal was of paramount interest to the provider community. Debate over whether audio-only encounters provide the optimal environment for the delivery of quality patient care turned out to be a considerable hurdle. Throughout these discussions, PAMED insisted that audio-only encounters failed to effectively establish a physician-patient relationship, a bond that is the very foundation of appropriate medical care.

As the bill is currently drafted, both audio and visual technology must be available should either party — physician or patient — request it. Thus, if a physician considers it necessary to see a patient using audio and video technology, then both options must be available. Conversely, if a patient believes their symptoms necessitate visual confirmation from a physician, then the patient should also have the opportunity to utilize audio and visual technology during their consultation.

PAMED remains optimistic the General Assembly will ultimately pass a comprehensive telemedicine bill during the current legislative session. In doing so, Pennsylvania physicians will be able to use advanced audio and visual interactive technology to treat their patients knowing that statutory safeguards exist. Technologies such as FaceTime, Skype, and others can be more than just a means to communicate with friends and family — they can be valuable extensions of a physician's ability to care for patients.

On behalf of physicians who utilize telemedicine, PAMED's government relations team will continue to advocate for this critical piece of legislation.

Stay up to date on this and other PAMED advocacy priorities at *www.pamedsoc.org/Advocacy*.

For information about PAMED's Legislative Affairs, contact David Thompson at dthompson@pamedsoc.org.

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Penn State Health Innovates with Radiology "Failsafe" Program

Failsafe proves effective at preventing delayed care and providing greater peace of mind for both patients and providers

BY MICHAEL A. BRUNO, MD, FACR

CASE STUDY

A patient is brought to the emergency department (ED) of a major medical and trauma center by ambulance after an automobile accident. The patient has been hurt, but luckily the tests show that injuries are minor; CT scan confirmed that the patient suffered no solid organ injury and had no broken bones — but the radiologist noted what might be a small kidney nodule and recommended follow-up imaging, just to be sure.

At discharge, the emergency physician noted the recommendation, but didn't explicitly mention it since this follow-up would need to be done after discharge by a regular primary care physician (PCP). The ED doctor made a point to instruct the patient to follow up the following week with his PCP. The patient said he would do so, and signed the discharge papers — but the recommended follow-up simply didn't happen. The patient reasoned that he shouldn't take the time or spend the money for another doctor visit so soon; after all, he'd just been seen by a doctor in the ED and that doctor had scanned him from top to bottom, so surely he is good for another year at least, right?

A year later, he does see his PCP for an annual routine visit, and he is found to be severely anemic. On questioning, he admits to his PCP that he has had some fatigue, has been a little short of breath lately, and he also had some recent unexplained weight loss and nagging back pain, which has been going on for months. The doctor orders some tests, including a new CT scan, and he is found to now have metastatic renal cell carcinoma, with lesions in his lungs and spine, later confirmed by biopsy. It was discovered that he had a prior CT scan a year ago — even he had forgotten about that. When the radiologist compared his current scan to his trauma CT of a year ago, it is clear that the questionable kidney nodule that was flagged by a radiologist for follow-up a year earlier has now grown into a large malignant tumor.

It is clear to everyone what has happened: with his cancer diagnosis having been delayed by a year, his chances of survival have essentially been lost.

This case is fictionalized, but stories like this one occur every day in hospitals nationwide, and are even more common now that CT utilization has increased exponentially, especially in EDs.

It was a case very much like this one that prompted Penn State Milton S. Hershey Medical Center Department of Radiology to search for a way to prevent lost follow-up of incidental findings. Penn State has taken the lead to address the issue of improving the communication of our follow-up recommendations for incidental findings with a program called Failsafe, in which patients are contacted directly when appropriate incidental findings are discovered on their scans. A letter urges them to follow up with their PCPs to determine what, if any, follow-up is appropriate.

In the past six months alone, 70 percent of the patients that our Failsafe team contacted have indicated that they did *not* know about their incidental findings and follow-up recommendations until they were contacted by our Failsafe nurse. The program goes beyond the standard of care to ensure patients get the opportunity to address any incidental findings in a timely manner.

The team developed Failsafe after we learned about a number of ED patients at Hershey who didn't receive the recommended follow-up care to evaluate their incidental radiology findings and then later, as in the case study, presented to their doctor with advanced disease. Chances of a good outcome were significantly diminished. On investigation, it was found that in almost every case the patient's PCP, if there was one, was never alerted to the incidental findings and was often completely unaware of the patient's ED visit. Further, we found that patients themselves were generally unable to name their PCP during their ED visit, so it was not possible to simply route a copy of our report to their PCP to address this communication gap.

As a result, for the majority of ED patients with incidental findings that require follow-up, their PCPs were simply never told about the findings. Even when patients themselves were informed of their incidental findings in the ED and clearly told that they needed to follow up with their PCPs, most simply didn't do it. We discovered that many patients leave the ED with the mistaken impression that they've been thoroughly evaluated by a doctor and that anything wrong with them has been addressed.

We found that most patients don't realize that emergency physicians provide only acute management of their single presenting condition. And, despite being instructed by the ED doctor to do so, most of our patients don't seem to understand the need to follow up with their PCP following an ED visit, and so they simply don't.

FAILS

DEVELOPING A SOLUTION

To close the gap, our team decided that we would *use the patient as a messenger* to carry our message to their PCP, who could then discuss our findings and recommendations with them and decide what ought to be done. Our thinking was that patients themselves have the most invested in the information, so they are the stakeholders most likely to reliably convey the message and help us communicate better with the clinicians we serve.

We didn't feel that there was an IT-based notification solution that could be more effective than the patients themselves, acting as "homing pigeons" on their own behalf, delivering our message directly to the single physician in the best position to act on the information. We knew that this was not a problem we could solve in the "back-end," since there is often no way to reliably identify the correct PCP for an ED patient, especially when that PCP is outside of our hospital physician group.

"THE PROGRAM GOES BEYOND THE STANDARD OF CARE TO ENSURE PATIENTS GET THE OPPORTUNITY TO ADDRESS ANY INCIDENTAL FINDINGS IN A TIMELY MANNER."

With Failsafe, our radiologists flag cases with incidental findings which require follow-up, but which are not critical enough to warrant immediate action by the ED. We send these patients a standard letter, with minimal customization, which simply informs the patient that they have an incidental finding on a scan or X-ray that we believe requires follow up by their PCP. To protect patient privacy, the letters do not state any specific findings or follow-up recommendations. There is a version for children that is addressed to the parents, and there are both English and Spanish language versions, but other than that, all of the letters are the same. For patients without a PCP, an expedited visit with a physician from Penn State Hershey's Department of Family and Community Medicine is offered.

In creating Failsafe, we assembled a workgroup that included emergency physicians and PCPs, an attorney from the hospital's legal team, the chief quality and chief medical officers, and the department chairs of the emergency department, radiology department, and the acting chair of Family & Community Medicine at the time, William Bird, DO. There was some concern about how to handle patients who didn't have a PCP. "We agreed to take all of those patients as new patients," says Dr. Bird. "The letter provides a number that patients without a primary care physician can call, and we make it a priority to address their findings as soon as possible."

EXPANDING THE PROGRAM

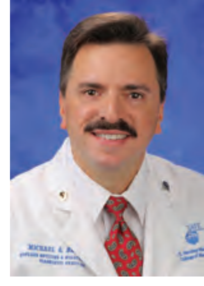
We took the extra step approximately one year ago of hiring a dedicated nurse who follows up the letters with a personal phone call to the patients to ensure they received the letters and encourage them to schedule their follow-up appointments with their PCP. Our Failsafe nurse, Nicole Seger, RN, MSN, CPN, is also a quality and patient safety analyst, employed by the Patient Safety Department. She is able to collect and analyze data to perform quality and outcome analytics on Failsafe patients.

She has been engaging patients personally — and collecting substantial data — for more than a year now. "Most of the patients I've called have been glad to receive the letter and have indicated that they intended to follow up with a primary care physician," Seger says. "They also say the phone call, and the fact that I reach out directly, increased their motivation to follow up."

Last year, the program was expanded again, this time to include all patients who undergo imaging at Penn State Health, including those referred for scanning from community providers outside of our health system. As a result of this recent expansion to Failsafe, many community physicians will soon be hearing from their patients who receive a Failsafe letter and a call from the nurse.

FE

We believe that our experience with Failsafe in the ED population at Hershey could be generalized to all of our patients who have incidental findings that aren't followed up as reliably as we would like. We can do more good for more patients and provide better service to our referring physicians in the community if we include all imaging patients in Failsafe. By doing so, we hope to prevent even more patients from enduring the potential harms associated with delayed care, and to provide our physician-customers with greater peace of mind.



Michael A. Bruno, MD, FACR, is the professor of radiology and medicine, chief of emergency radiology, and vice chairman for quality and patient safety at Penn State Health in Hershey.

Reference:

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FEEL NO PAIN

NEW PROCEDURE TARGETS SPECIFIC NERVES TO PROVIDE RELIEF

Kam Peter battled Chronic Regional Pain Syndrome for 15 years, ever since a hernia operation in 2001.

The registered nurse from Jersey Shore, Pa. remembers going through 15 operations, which only provided temporary relief for chronic intractable pain that extended from her hernia incision toward her abdomen, into her thigh, and sometimes down her leg behind her knee and into her foot.

Debilitating pain is a widespread problem, with about 76.2 million Americans — that's one in four — having suffered from pain that lasts longer than 24 hours, according to the National Center for Health Statistics.

By 2012, Peter was forced to give up her career as a registered nurse because of the dosages of narcotics and other medications she needed to relieve hot burning pain that felt like bee stings or being stuck by straight pins. The pain became so severe that, at times, she could not walk because the sensation of clothing against her skin induced such intense pain.

Enter St. Luke's University Health Network. Peter heard about a new procedure called Dorsal Root Ganglion stimulation being performed by doctors at St. Luke's. The ultra-specific spinal cord stimulation procedure provides unprecedented relief for patients with CRPS in the lower body, particularly the foot, knee and groin.

Kam Peter is feeling better and back to spending quality time with her grandchildren.

St. Luke's is one of the first hospitals in the country, and the only one in the Lehigh Valley, performing Dorsal Root Ganglion stimulation, a specific spinal cord stimulation approved by the FDA in April 2016.

Functional neurosurgeon Steven Falowski, MD and pain specialists Scott Loev, DO; Farooq A. Qureshi, MD; and Jason M. Erickson, DO, MSPT, of St. Luke's Spine & Pain Associates were among the first doctors in the United States to receive special training in Dorsal Root Ganglion stimulation. Loev serves as the medical director of St. Luke's Pain Medicine Program.

Performed in an outpatient setting, DRG stimulation targets the exact bundle of sensory nerve cell bodies to relieve pain where it occurs. "It's a pretty ground-breaking procedure with a limited launch," Falowski says. "It shows St. Luke's to be on the cutting edge by having access to it before other institutions in the country."

CRPS, a chronic pain syndrome brought on by injury or trauma, affects the way the central nervous and peripheral nervous systems receive pain signals from the brain. Pain-level registers out of proportion compared to the initial trauma. Traditional spinal cord stimulation hasn't been very effective in pain management for CRPS patients, who often end up using high doses of opioid or narcotic medications to treat the pain.

Loev, Qureshi and Erickson perform a trial procedure to see if the procedure provides relief. They use a catheter to place the electric leads into the epidural space and place the lead along the proper DRG. If the procedure relieves the pain symptoms, patients schedule with Falowski for the permanent implant.

Falowski implants a small non-rechargeable generator that provides the electrical stimulation. The patient receives a handheld remote control that allows them to adjust the strength of current, or even power it off.

"DRG literally localizes pain relief for one body part," Loev says. "For people who have significant pain in just the right foot, we can guide the catheter along that nerve root until it's over that nerve bundle to stop the pain from recurring."

Peter underwent the two-step outpatient procedure last June.

"I can finally see a light at the end of the tunnel," Peter says of her pain relief, noting that she has reduced the use of pain medication by more than one half. "Before DRG, it was all black. As good as it's gotten, I think it's going to get to where it needs for me to get my life back. I worked too hard for that nursing career to give it up."

Qureshi performed the procedure on a CPRS patient who was injured while serving in Vietnam. He underwent multiple surgeries with limited pain relief until receiving the DRG stimulation.

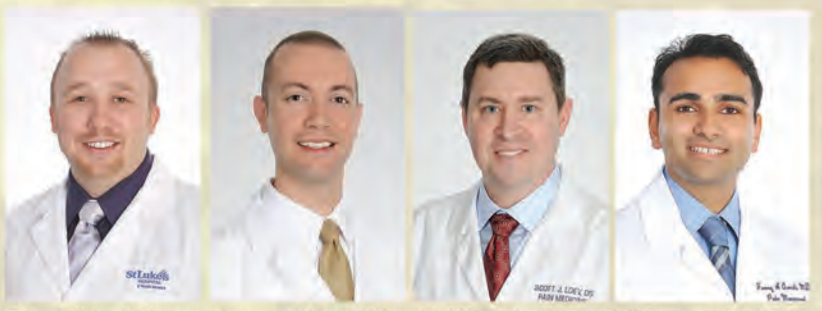
"When I went into the recovery room of the patients I trialed and turned the [transmitter] on, they were so happy they had such relief," he says. "I have never seen that kind of effect with traditional spinal cord stimulation."

Erickson is equally enthused about the procedure.

"It's amazing to see the patient living with this pain, and right after, I've seen them cry because it's unbelievable that they finally have relief after having this pain for so long," he says.

DRG results have been amazing, Falowski said after performing more than 40 of the procedures.

"The success rates we're having are near 80 percent complete pain relief. In this day and age where opioid addiction is in the spotlight, this procedure can keep people off opioids and narcotics," Falowski said.



From left to right, neurosurgeon Steven Falowski, MD and pain specialists Jason M. Erickson, DO, MSPT, Scott Loev, DO and Farooq A. Qureshi, MD of St. Luke's Spine & Pain Associates

For more information, contact St. Luke's Spine and Pain Associates: 484-526-7246.

Advertorial submitted by SLUHN.

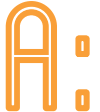
PAMED's Leadership Academy

SPURS INNOVATION

Scholarship recipients from PAMED's Year-Round Leadership Academy were asked about diverse needs in their practice and what innovation or redesign challenges they would like to address. Here's what they told us.

Learn more about the Year-Round Leadership Academy and our other leadership offerings at *www.pamedsoc.org/LeadershipAcademy.*

WHAT IS YOUR INNOVATION OR REDESIGN CHALLENGE?



DR. PENCE:

I would like to bring about change that will impact the overall care of patients in my pediatric clinic and also enhance the workflow of the office in general. I have a number of ideas on how to make this happen, but do not always have the best way to implement these plans.

DR. MAKARY:

One of my leadership goals is to help my peers to adapt to the continuous changes in the health care system. I will act as a catalyst for change and innovation, and break down some organizational barriers. This will energize the team to embrace changes and champion the transformation of the organization in new and effective directions.

DR. SIVENDRAN:

I am a hematologist/oncologist at PENN Medicine/Lancaster General Health with an interest in early integration of primary- and consultant-level palliative care in our patients with advanced cancer or complex psychosocial needs. As co-chair of our Palliative Oncology Disease Team, I am tasked with innovative programmatic development of these services. Additionally, I am using my expertise in clinical research to grow and motivate our team to engage in investigator-initiated clinical research projects in the palliative oncology space.

Growth of this program will provide our patients with much-needed symptom and psychosocial support earlier in their disease course. Results from research related to our own patient population will allow us to better target interventions specific to our community as well as contribute to the national conversation on early integration of palliative care.

DR. KIRK:

I am the practice-wide leader for ICD-10 implementation within our large group practice. I took on this role in April 2015, and since that time have trained more than 150 providers within our practice, as well as residents in the local residency program. Additionally, I am the physician in charge of IT implementation and our EHR, so I am in regular contact with our vendor for improvements and bug fixes. In my "off-time," I travel to our various practice sites to help other providers become more efficient with the use of the EHR.

ASHLEY N. PENCE, DO

UPMC Susquehanna

Pediatrics, Williamsport Regional Medical Center

Williamsport

SHANTHI SIVENDRAN, MD

PENN Medicine/Lancaster General Health

Ann B. Barshinger Cancer Institute

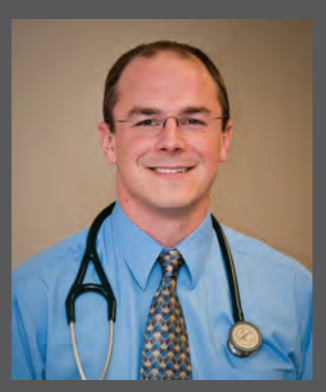
Lancaster

MINA MAKARY, MD, FACP, BCMAS

Geisinger Health System

Geisinger Community Medical Center

Scranton

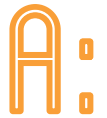


QUINN KIRK, MD

Family Practice Center, PC

Hughesville

Q: WHY DID YOU CHOOSE PAMED'S YEAR-ROUND LEADERSHIP ACADEMY?



A:

DR. PENCE:

I chose to be part of the Year-Round Leadership Academy to develop foundational leadership skills that will be useful over the course of my career. I think this program will help me with skills to develop and execute good action plans, key skills I will need to use as I navigate through the different areas of my current position where I find myself involved in more leadership roles.

DR. MAKARY:

I am expecting the Year-Round Leadership Academy to help me to identify how to transition my team through the stages of change, improve my ability to lead change initiatives, and build strong communication skills to increase influence, promote collaboration, and engage others.

DR. SIVENDRAN:

The Leadership Academy will help me to navigate the business side of medicine that is required to launch any new program off the ground, as well as give me the tools to interact and negotiate with other physician and non-physician leaders in our health system to grow these initiatives. I am excited to be part of the Year-Round Leadership Academy and learn to harness my passion on these topics to go from advocacy to action.

DR. KIRK:

As pay for performance looms, one of the big challenges for a group our size is getting all the providers in the group on board with quality markers and their importance. As in any practice environment, we have some physicians content to continue as is and reluctant to move on with documentation requirements or quality metrics. One of the things I really wanted to take away from the leadership training was improving my skills in engaging the providers in our group, and helping them desire to make the changes toward high-quality, cost-effective care rather than forcing changes on them. I feel as though I am good at specific project implementation, but I also wanted to learn more about long-term strategic planning.

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Dates/Courses:

- **Friday, March 23, 2018** — Two Hats, One Team: Challenges Associated with the Dual Roles of Administrator and Clinician
- **Friday, April 27, 2018** — Health Care Consolidation: Impact on Physician Executives
- **Friday, May 18, 2018** — Influential Presentations
- **Friday, June 15, 2018** — IT Solutions for Future Health Care Systems
- **Friday, July 13, 2018** — Enlightened Leadership and Change Management
- **Friday, Aug. 17, 2018** — Managing Virtual Teams

Cost: Members: $150 per course or $700 for the series.

Non-Members: $415 per course or $2,000 for the series. Save by joining PAMED at *JoinNow.pamedsoc.org.*

Learn more and register at *www.pamedsoc.org/PhysicianLeaders*.

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Times: 8 - 8:30 a.m. Networking Breakfast; 8:30 a.m. – 12:30 p.m. Workshop

Dates/Courses:

- **Thursday, May 24, 2018** — Communication Strategies
- **Thursday, July 19, 2018** — Strategic Thinking and Decision Making
- **Thursday, Sept. 13, 2018** — Employee Engagement/ Performance Management

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The LifeGuard Approach

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Veena Graff, MD
Arthur Kett, MD
Russell Bell, MD
Marcia A. Lammando, RN, BSN, MHSA

Course Details

Dates:
May 3-4, 2018
Nov. 8-9, 2018

Location/Time: TBD

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INNOVATION BLOOMS AT JEFFERSON

THE HOME BASE OF PAMED PRESIDENT THEODORE CHRISTOPHER, MD, FACEP, CHARTS THE FUTURE OF MEDICINE

BY ED FINKEL

From the use of telemedicine in care delivery, to simulation in medical education, the Sidney Kimmel Medical College (SKMC) of Thomas Jefferson University and its hospitals — where PAMED President Theodore Christopher, MD, FACEP, serves as professor and chairman of emergency medicine — have aimed for the leading edge on a variety of fronts.

"Telemedicine is going to be huge," says Dr. Christopher. "The insurers are expecting us to decrease costs and increase quality; we can do that through virtual visits. Students are getting more clinical exposure, earlier. When our future doctors are locked in the basic science labs for two years, it's demoralizing. If you put the clinical practice of medicine in front of them much sooner in their education, they remember why they wanted to go to medical school in the first place."

TELEMEDICINE BEAMS PATIENTS IN ·

The benefits of telemedicine go beyond satisfying the dictates of insurers to providing appropriate and, if needed, rapid medical care, Dr. Christopher notes. For example, a doctor can see a patient located miles away who might be having a stroke and prescribe a clot-busting agent immediately.

Surgeons at Jefferson already have been using telemedicine for post-operative care for patients who live remotely, such as patients who need surgical wound checks but live two or three hours away. "There's a lot of emphasis on post-acute care in general — for example, when patients leave the hospital, making sure they're taking the right medication, have obtained the necessary follow-up blood tests or X-rays, and have scheduled the appropriate visit with their private physician or specialist," he says.

And, then there's the increasing ability to interpret health-related data from a variety of sources. An asthmatic patient who is having trouble breathing and is an hour away from their pulmonologist can have an IBM Watson type assessment of their local environment, where an unusually high pollen count might be the real source of a breathing problem, Dr. Christopher says.

"We can feed that, and all sorts of information, into a 'big data' dump and then give the doctor some real information," he says. "For example, blood pressure. What's your blood pressure really doing over the course of a day or week? Might that be more valuable than taking a blood pressure reading at one point in time?"

Dr. Christopher adds there are practical reasons to implementing telemedicine as well. "You're parking in the city, then waiting an hour to see a doctor — it's an all-day affair. Whereas you can access a telemedicine physician from the convenience of your home and complete your scheduled office visit in 15 minutes. It's the 21st-century version of a physician house call."

Left to right: Dimitri Papanagnou, MD, Theodore Christopher, MD, FACEP, Bon Ku, MD, MPP

Judd Hollander, MD, professor of emergency medicine, senior vice president of health care delivery innovation, and associate dean for strategic health care initiatives at Jefferson, likens the advent of telemedicine to the impact of e-commerce on the retail landscape. “The biggest thing is, care is going to the patient,” he says. “For many patients, telehealth can mean the difference between seeing their doctor or receiving no care at all. Patients will not need to be going to the doctor’s office any longer, much like people don't need to go to the mall to buy clothing. Medicine is always late to adopt new technology, but its time is coming now.”

Telemedicine does come with clinical tradeoffs, Dr. Hollander acknowledges. “If I’m seeing a person on a video call, I can’t generally listen to their lungs,” he says. “But, I can see their home environment, and what it’s like, and how they’re dressed, and who else is home with them — questions that are infrequently assessed in the office. I might be able to get to a more actionable next step, even though I don’t have every single tool that I do in an in-person visit.”

While some clinicians remain concerned about the fact that telemedicine has its limits, Hollander points out that both offices and emergency departments do, too. “Sometimes I need radiographic imaging; sometimes I need to admit the patient to the hospital,” he says. “Nobody pretends you can do everything via video. I just need to be a good doctor and do everything that’s appropriate, and then make an appropriate referral ... It’s just a different way of delivering the same care.”

Dr. Christopher believes the limits of telemedicine will shrink over time, in part thanks to advanced robotics and wearable device technology. For example, the technology will soon exist to be able to examine a patient’s abdomen remotely and determine if they are having appendicitis. “You’ll be able to get a lot of information without having to be face-to-face,” he says. “I’m not saying we’re going to totally replace face-to-face.”

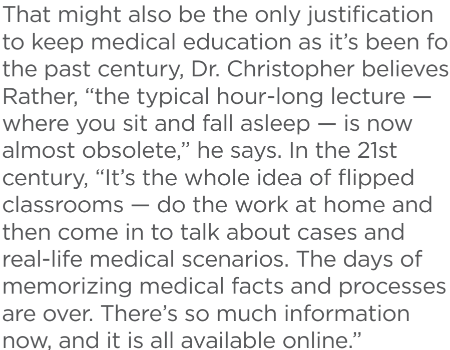
But, eventually, Dr. Hollander believes clinicians will be able to deliver everything short of surgery via telemedicine. For now, Jefferson is offering the Jeff Connect app, where patients can go online and see an emergency physician at the hospital 24/7/365, as part of a virtual emergency department in which doctors can, for example, order imaging or lab tests.

“We’re able to take care of 80 to 85 percent of complaints without an in-person visit,” he says. “We believe that once we incorporate the technology to do imaging, we can get that up to 95 percent, significantly changing how much it costs to provide medical care.”

Dr. Hollander notes that the regulatory environment in Pennsylvania will need to change before insurers pay dependably for telemedicine visits; while New Jersey just passed a “coverage parity” law, Pennsylvania has not yet done so. “If a payer has no incentive to pay, then guess what? They’re not going to pay,” he says. “If we can’t get reimbursed for doing it, that means patients are less likely to have it, which means we are caring for patients in the most inconvenient and expensive way possible.”

At some point, patients might even be able to see a doctor face-to-face in their home via a 3-D hologram. “It will be, ‘Beam me in, chief,’ like in ‘Star Trek,’” Dr. Christopher says. Overall, he adds, “The quality will be improved, the patient happier, the cost lower — there’s really no justification not to do it, except to say, ‘That’s the way we’ve always done it.’”

EDUCATIONAL REDESIGN •



That might also be the only justification to keep medical education as it’s been for the past century, Dr. Christopher believes. Rather, “the typical hour-long lecture — where you sit and fall asleep — is now almost obsolete,” he says. In the 21st century, “It’s the whole idea of flipped classrooms — do the work at home and then come in to talk about cases and real-life medical scenarios. The days of memorizing medical facts and processes are over. There’s so much information now, and it is all available online.”

Jefferson’s new immersive curriculum, JeffMD, enables students to gain clinical exposure from day one, says Dimitri Papanagnou, MD, associate professor and vice chair of education in the Department of Emergency Medicine and assistant dean for faculty development at SKMC. “Months into their first year, students will have the unique opportunity to be immersed in a variety of clinical settings, including the emergency department,” he says. “First-year students are going to get their feet wet, clinically, and assist providers with transitions in care from the ED. This unique experience will afford them the opportunity to become active members of the clinical team.”

Beyond the classroom, Dr. Papanagnou and his colleagues have used medical simulation for the past decade to replicate life-like clinical environments, using mannequins and standardized patients, through which medical students can practice high-stakes medical interventions, such as inserting a breathing tube or even delivering a ‘robotic’ baby. “We train

learners across the entire continuum with simulation technology — from students and residents to senior faculty," Dr. Papanagnou says. "Our training programs are keen to leverage simulation to address the affective, cognitive, and behavioral aspects of learning. Whether it's using deliberate practice to improve procedural or communication skills, simulation is the ideal experiential tool for high-stakes, low-frequency events we get very worried about."

But, while learners can demonstrate competency up to a point in such settings, skills in the simulation center don't necessarily translate well to the actual work environment, with its minute-by-minute pressures and intricate team-focused dynamics. To address this, Jefferson has been taking steps to move simulation into clinical environments: the intensive care units, the emergency department, the clinical floors, and even the operating rooms.

> "You'll be able to get a lot of information without having to be face-to-face."
>
> -Dr. Christopher

"If we want to address training for how we address strokes, for example, we'll have an actor trained to replicate the signs and symptoms of an acute stroke," he says, "and have them arrive to the ED. Diagnostic tests will be ordered, including a simulated CT scan, and then all team members involved — including the standardized patient actor — will have a chance to debrief all the events that took place to better inform future performance."

Before a trainee performs a certain procedure, they have the opportunity to actually practice the procedure in the clinical environment, just-in-time, repeatedly until achieving mastery level — whether it's an invasive procedure, like inserting a breathing tube, or a delicate task involving fine motor skills, like a lumbar puncture, Dr. Papanagnou says.

"As a faculty member, I am required to supervise my trainees to execute these procedures effectively," he says. "But, at time zero, I may not know their procedural skill set. Having task trainers in the ED for just-in-time training easily addresses this. Simulation companies have created task trainers that allow learners to practice a task again and again and again, while getting formative feedback from their supervisor to improve their skills, bolster their confidence, and build their muscle memory — minutes before the procedure."

To account for the broader societal issues facing the medical field, Jefferson instituted a design thinking program about three years ago, says Bon Ku, MD, MPP, associate professor of emergency medicine and assistant dean for design thinking at SKMC. For example, he recalls getting burned out as an emergency medicine physician early in his career while treating the same "super-utilizer" ED patients, many of whom experience housing instability.

"I was not really making people healthier but just treating complications and diseases," he says. "Emergency departments are a great barometer for a population's health ... We're seeing the same problems of untreated diabetes, and obesity, and the opioid epidemic. Despite four years of medical school, four years of residency, and fellowship training, I did not have the toolkit to address these systemic problems, including many social determinants of health."

Through design thinking, Dr. Ku and his colleagues are working to teach medical students and residents, and even faculty, how to approach complex, even systemic problems of the sort that vexed Dr. Ku early in his career. "How do I decrease the length of stay for the patients I see, so they're not waiting six hours to be discharged from the emergency department?" he says. "I have no idea how to do that. I've never been trained."

Judd Hollander, MD

Theodore Christopher, MD, FACEP

Dimitri Papanagnou, MD

Bon Ku, MD, MPP

Photo credit: Shannon Fretz Photography

Ideally this process involves participatory design, in which patients help brainstorm solutions. "Why don't we bring in a patient who's actually been to a fast-track area in our emergency department and have a brainstorming session with them?" Dr. Ku says. "Any other industry would focus on the end user. In medicine, we don't do that. Often, we design solutions without really getting the patient's point of view."

Jefferson educators are also tapping into the tech-savviness of the millennial generation to further their education, leveraging a hands-on, interactive learning style that allows instructors to "gamify" content, Dr. Papanagnou says. "We've integrated technology and software into coursework to recreate virtual clinical adventures, where students are immersed in the game, make clinical decisions, are allowed to make mistakes, and receive live, formative feedback on the decisions they're making," he says. "We have several homegrown products that we've developed, and through the support of the institution, we have been able to integrate robust software from third-party vendors."

Jefferson also has developed interactive content for its faculty learners, who Dr. Papanagnou notes, are typically the hardest to reach because they often do not have the time to attend workshops and training sessions. An example of such a program, developed by Jefferson's Center for Teaching Learning (CTL), is the Interactive Curricular Experience (iCE) program. The program makes it easy for educators to create user-friendly interactive modules that learners can engage with on an iPad, even if they do not have any previous experience with putting together an e-module.

"Historically, if you wanted to independently design a sleek, aesthetically pleasing digital module to complement your coursework for your students, you would need to be pretty savvy with technology and software," he says, adding that one of Jefferson's educational products to use iCE was a certificate program for faculty at Jefferson and elsewhere to learn the art of telehealth. "This homegrown program at Jefferson is very easy to learn. Faculty are attending faculty development and CTL workshops, and are learning the skills to build modules on iCE on their own to supplement their educational programs with technology. We're always looking for ways to improve our educational programs with evidence-based methodologies and innovative technology."

Dr. Christopher adds, Jefferson has created a new Institute for Emergency Health Care Professions to provide certificate programs for students and faculty who will be working in the various health care jobs of the future — such as telehealth technicians and providers. "It is an exciting time to be in medicine," he says.

ED FINKEL IS A FREELANCE JOURNALIST, MEDICAL WRITER, AND EDITOR WHO LIVES IN CHICAGO.

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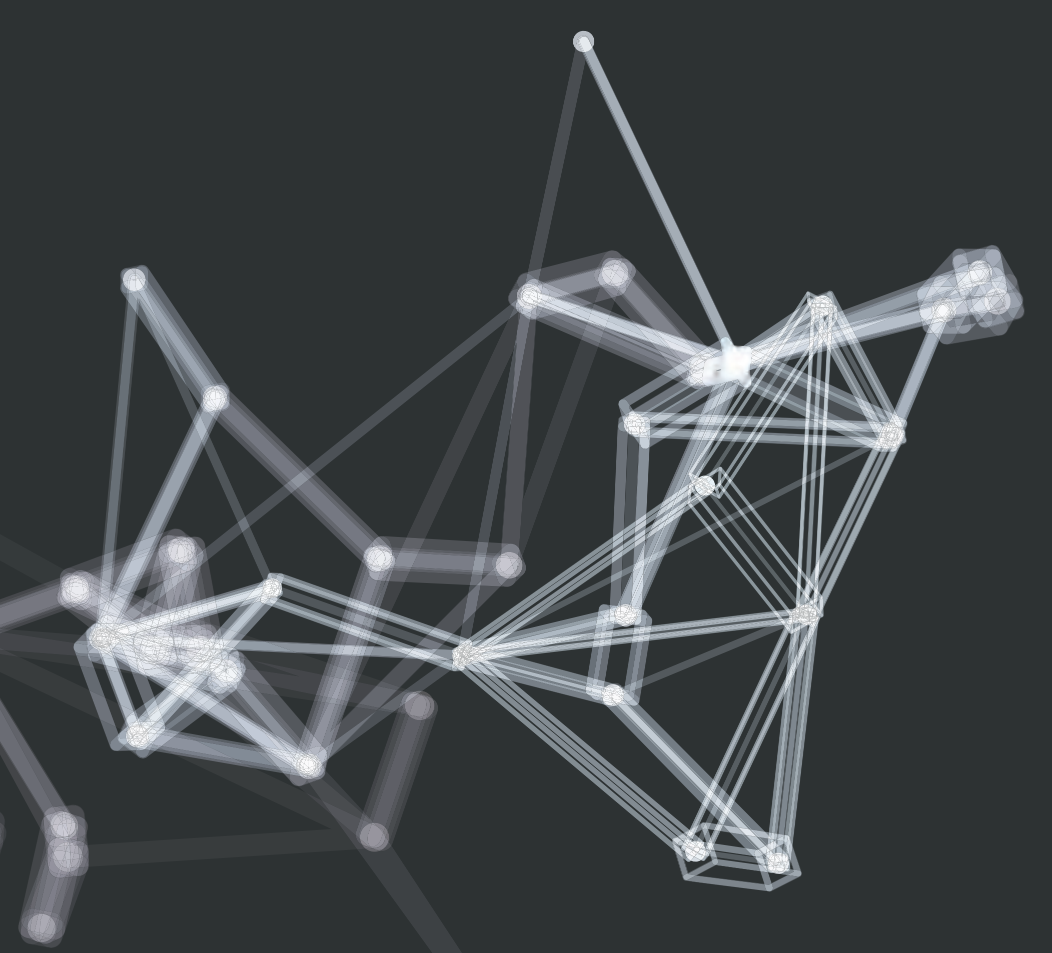


INNOVATION IN MEDICINE AND THE ROLE OF PHYSICIANS

A Q&A WITH DR. KAREN MURPHY

Pennsylvania Physician recently sat down with Karen Murphy, RN, PhD, executive vice president, chief innovation officer, and founding director of the Steele Institute for Healthcare Innovation at Geisinger, to discuss her thoughts on innovation in medicine in Pennsylvania and the role of physicians. Prior to joining Geisinger in September 2017, Dr. Murphy served as Pennsylvania Secretary of Health.

PP: What intrigued you about the executive vice president, chief innovation officer, and founding director of the Steele Institute for Healthcare Innovation position at Geisinger?

I'm very excited about this position! I started my career as an RN and worked in the clinical arena for many years, hospital administration, followed by work in the public sector at the Centers for Medicare and Medicaid Innovation and the commonwealth.

In all settings, I worked with dedicated individuals who continuously worked to improve the quality of health care that we deliver and lower the cost of care. Innovation is key. We need to consciously stand back and look at health care in a different and innovative way — redesigning and looking at different payment models, leveraging technology, etc.

Innovation is a fundamental activity and strategic priority for Geisinger. It's in the organization's DNA.

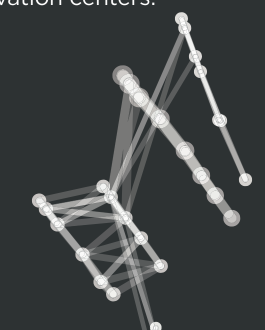
PP: From your recent experience as Pennsylvania Secretary of Health, what innovative ways to improve health and transform health care delivery has Pennsylvania seen in the past couple of years?

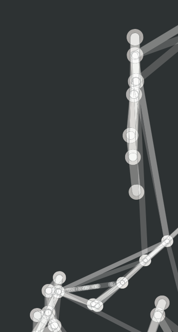
There is a tremendous amount of innovation going on across the state, and Pennsylvania really is among the leaders in health care innovation across the country.

When I worked for the state, we created the first deputate in the Pennsylvania Department of Health dedicated to promoting health innovation. The state has engaged stakeholders across the commonwealth to look at and promote the advancement of health innovation. In Pennsylvania there are many providers implementing new delivery models, such as Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), and bundled payment models.

Two years ago, the state created the Pennsylvania Rural Health Transformation Initiative — an initiative where rural hospitals are testing a global payment model. The state was awarded $25 million by the federal government to improve the health of those residing in rural communities across the state.

There are also other great health care systems across the state with innovation centers.





PP: In a recent article, it was said that Geisinger has an emphasis on patient-centered care. How does innovation play a role in this?

What motivates all of us in health care is always the patients and those residing in the communities we serve. Patients are at the center of everything we do. We want to improve the quality of health care that we deliver, and the health of the communities.

Patients are at the center focus of innovation. Our goal is to make a difference in their experiences and improve their health, encounters with the health care delivery system, and outcomes.

PP: Both now and into the future, what are your goals related to innovation in medicine at Geisinger?

Initially, our goal is to look at innovation currently underway, identify successful trends as well as what hasn't worked, and then plan the future. We will be concentrating on further developing innovation in the areas of improving health and the health status of the communities we serve, particularly in vulnerable populations.

For example, Geisinger currently has a terrific innovative approach to alleviating food insecurity in order to improve health. We would like to expand this effort.

Some of the other areas that we would like to develop innovations around include:

- The social detriments impacting the health of the residents in our communities, which will result in higher quality outcomes at a lower cost.
- Building on already established innovations — like ACOs, PCMHs, and bundled payment models — and lessons learned in developing new payment and delivery models as we move forward.

"PENNSYLVANIA REALLY IS AMONG THE LEADERS IN HEALTH CARE INNOVATION ACROSS THE COUNTRY."

> “PHYSICIANS ARE A KEY PART OF THE HEALTH CARE TEAM, AND CAN BE EXTREMELY INSIGHTFUL TO IDENTIFY WAYS TO TEST AND DISSEMINATE NEW INNOVATIONS.”

- The cost of health care — reports indicate that the cost of health care is projected to continue to increase to 20 percent of the GDP within the next decade. We need to consciously look at ways to remove low-value services from the cost equation and increase the value of health care delivery in terms of expenditures.
- Developing an overarching value proposition for patients, providers, and communities that offers high-value services and encouraging providers to adopt new and innovative ways to deliver health care in a very comprehensive manner.

PP: Why is innovation in medicine so important in today’s health care environment? How can physicians play a role in innovation?

I’m so glad you asked this question! Physicians are a key part of the health care team, and can be extremely insightful to identify ways to test and disseminate new innovations.

Physicians can be helpful in reimagining the health care delivery system and working with teams to develop new care delivery models.

The evidence has demonstrated that there is a great deal of benefit in partnering with other health care providers on the team to look at new models of care that can result in better outcomes for patients.

In addition, we must also have every sector of the health care delivery system developing new partnerships, such as public health and community agencies, if we’re really going to make a difference in health care. Physicians are key to moving that in the right direction.

PP: Any other thoughts you want to share with Pennsylvania physicians related to innovation in medicine?

Physician engagement, leadership, and being part of the solution are essential in health care innovation. It’s a tremendously challenging position to have to innovate and operate at the same time. The contribution that physicians can deliver to innovation and finding ways to help our communities be healthier and health care delivery systems be stronger is critically important.

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Pennsylvania Top Physicians Under 40 Award
(Annual award) Recognizes early career physician members who are up-and-coming leaders.

Distinguished Service Award *(Annual award)*
Recognizes physician members for their lifetime achievements in medicine.

Physician Award for International Voluntary Service
(Annual award; international service in even-numbered years, community service in odd-numbered years) Recognizes physician members for their volunteerism in other countries.

Grant for Healthy Living in Ethnic Communities
(Annual award) $5,000 grant awarded to an organization that plans to improve health within an ethnic community through measurable goals and objectives.

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(The Everyday Hero award is a monthly award and nominations will be accepted throughout the year.)

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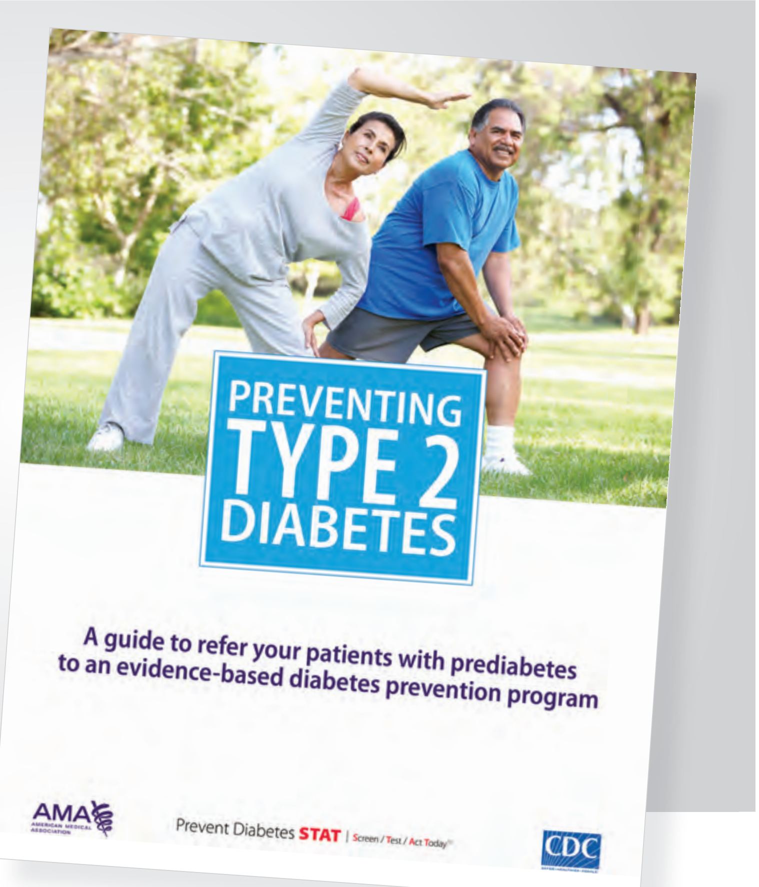


PAMED GRANT FOR HEALTHY LIVING IN ETHNIC COMMUNITIES

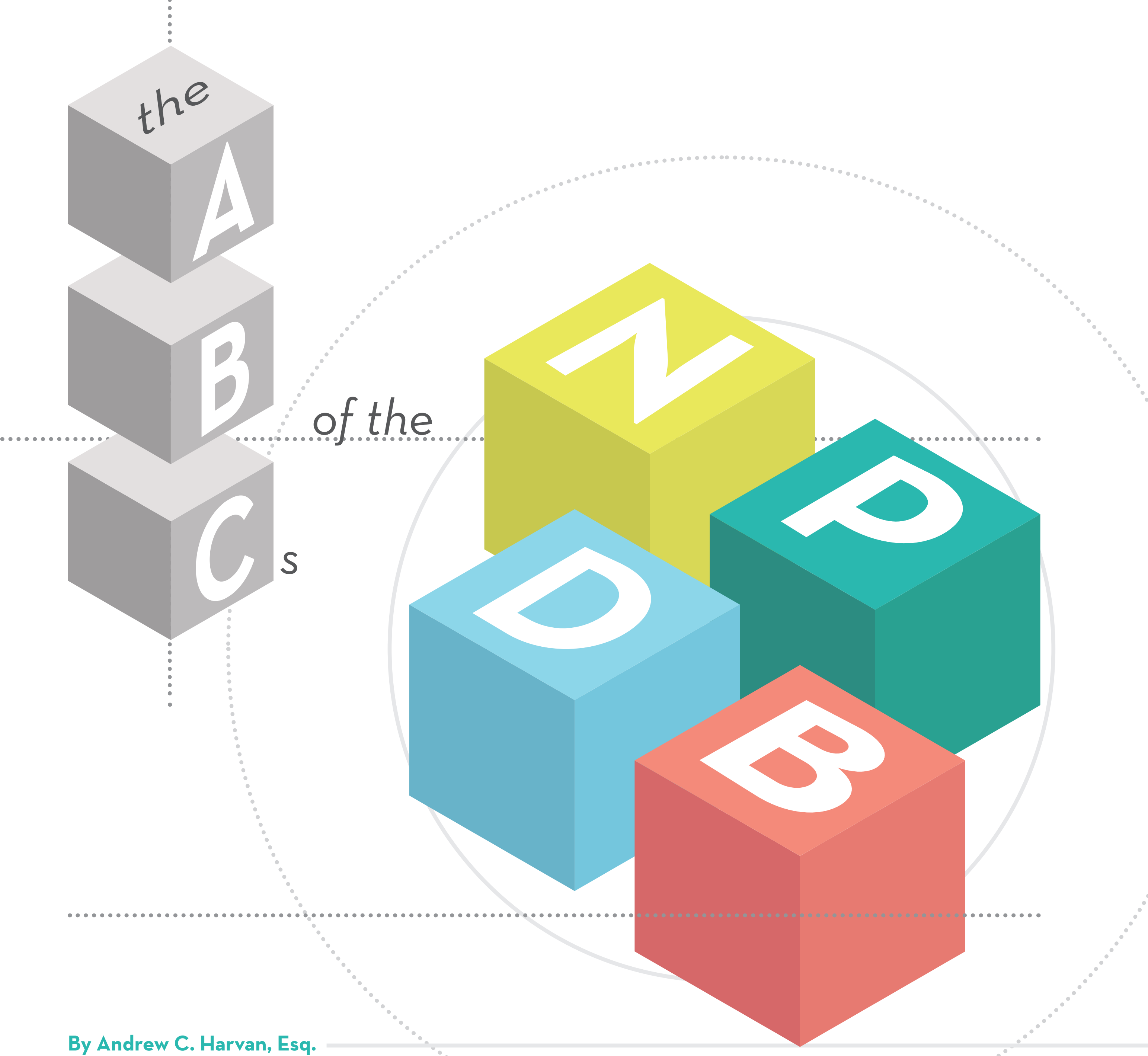
Community Volunteers in Medicine (CVIM), serving the West Chester area, has been recognized as the 2017 recipient of PAMED's Grant for Healthy Living in Ethnic Communities. CVIM was nominated for the $5,000 award by both the Chester County Medical Society and Delaware County Medical Society.

CVIM was founded in 1998 as a 501(c)3, free clinic staffed primarily by volunteers to address the need for increased access to high-quality primary medical and dental care as well as free prescription medications for the uninsured, vulnerable adults, and children living in poverty.

Today, their clinic serves as the premier medical and dental home for thousands of uninsured adults and children living in poverty or near poverty. More than half of CVIM patients are female, many serving as the head of their household. And, 20 percent of patients are children living in poverty. Nearly 60 percent of patients are of Hispanic origin.

PAMED selected CVIM from a statewide application pool after a committee of physicians reviewed the organization's upcoming goals and nomination papers.

the ABCs of the NPDB



By Andrew C. Harvan, Esq.

The National Practitioner Data Bank (NPDB) is a government repository that collects, stores, and discloses certain information concerning health care practitioners. Although many physicians may be aware of the NPDB, some of its intricate details may be of particular interest.

A negative NPDB report can have serious consequences for a physician. As a result of information contained in the NPDB, the physician may find their employment opportunities diminished and ability to obtain medical liability insurance hindered. Regardless of whether a NPDB report adequately reflects a physician's competence, it can be extremely difficult for a physician's career to fully recover. Thus, it is imperative that physicians understand who can report and what is reportable to the NPDB.

A BRIEF HISTORY OF THE NPDB

Due to a growing public concern that medical liability cases were occurring with increasing regularity, Congress passed the Health Care Quality Improvement Act of 1986 (HCQIA) to counter the frequency of such cases and thereby improve the quality of health care nationwide. Congress theorized that an interstate reporting system that collected and disclosed adverse data on practitioner conduct and competence was needed to restrict practitioners from moving from state to state without disclosure of their previous unprofessional conduct or incompetence.[1]

Under HCQIA, state boards of medical examiners and health care entities are required to report to the U.S. Department of Health and Human Services (HHS) all adverse actions that affect a physician's clinical privileges for longer than 30 days or a physician's license.[2] HCQIA also requires that medical malpractice payers report all payments made on behalf of a physician.[3]

Subsequent regulations promulgated by HHS, 45 CFR §60.1 et seq., formally created the NPDB, which became operational in 1990. The Bureau of Health Workforce of the Health Resources and Services Administration (HRSA), an HHS agency, administers the NPDB.

WHAT IS REPORTABLE TO THE NPDB?

The following actions are reportable to the NPDB:

- **Medical Malpractice Payments.** Entities that make a payment for the benefit of a health care practitioner in settlement of or in satisfaction (in whole or in part) of a medical malpractice claim or judgment must report payment information to the NPDB. There is no minimum reportable payment amount.[4]
- **Board of Medical Examiners Licensure Actions.** Boards of Medical Examiners are required to report adverse licensure actions based on reasons related to professional competence or conduct that:
  - » Revoke or suspend a physician's license;
  - » Censure, reprimand, or place on probation a physician;
  - » Or under which a physician's license is surrendered.[5]
- **Adverse Professional Society Membership Actions.** Professional societies must report professional review actions based on professional competence or conduct which adversely affect the membership of a physician in said society.[6]
- **State and Federal Licensure Actions.** Federal and state licensing and certification authorities must report certain actions taken against health care practitioners, providers, or suppliers. These actions include the following[7]:
  - » Revocation, suspension, reprimand, censure, or probation of a license, certification agreement, or contract for participation in a government health care program. Such action must be taken as the result of a formal proceeding.
  - » Dismissal or closure of a formal proceeding by a licensee resulting in the surrender of a license, certification agreement, or contract for participation in a government health care program, or leaving the state or jurisdiction.
  - » Any other loss of a license, certification agreement, or contract for participation in a government health care program, or the right to apply for or renew said license, contract, or agreement.

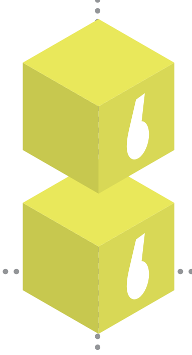
WHO CAN REPORT TO AND QUERY THE NPDB?

Only certain entities are eligible to report to and query the NPDB. The following entities are eligible to report to the NPDB:

- Medical malpractice payers
- Peer review organizations
- Professional membership societies
- Hospitals and other health care entities
- Health plans
- Private accreditation organizations
- State licensing boards and boards of medical examiners
- Federal and state law enforcement agencies
- Federal and state agencies administering or supervising the administration of federal or state health care programs
- Federal and state licensing or certification authorities
- Private entities administering federal health care programs under contract
- Quality improvement organizations
- Federal and state prosecutors
- State Medicaid fraud control units

Hospitals are the only entity required by law to query the NPDB[8]. Hospitals must query the NPDB when practitioners apply for clinical privileges, when practitioners seek to expand existing privileges, and every two years for practitioners on their medical staffs or who have been granted clinical privileges.[9] Additionally, hospitals may query the NPDB for professional review activities. Other health care entities may query the NPDB when making employment, affiliation, or licensure decisions.[10] Practitioners may perform a self-query at any time as well.[11] NPDB data is not available to the public.

[1] 42 USC §11101 • [2] 42 USC §11132-11133 • [3] 42 USC §11131(a) • [4] 45 CFR §60.7 • [5] 45 CFR §60.8
[6] 45 CFR §60.12(a)(1)(iii) • [7] 45 CFR §60.9-60.10 • [8] 45 CFR§60.17 • [9] 45 CFR §60.17(a)
[10] 45 CFR §60.18(a) • [11] Id.



The National Practitioner Data Bank (NPDB) is a government repository that collects, stores, and discloses certain information concerning health care practitioners.

  - Any other negative action or finding by a federal or state licensing or certification agency that is publicly available information, such as limitations on scope of practice, liquidations, injunctions, and forfeitures.[12]
- **Peer Review Organization Negative Actions or Findings.** Peer review organizations must report recommendations to sanction a practitioner. Such recommendations must be the result of formal proceedings.[13]
- **Private Accreditation Organization Negative Actions or Findings.** Private accreditation organizations are required to report final determinations of denial or terminations, based on formal proceedings, of an accreditation status that indicates a risk to the safety of a patient, or quality of health care services.[14]
- **Adverse Clinical Privilege Actions.** Health care entities must report adverse clinical privilege actions that are the result of a professional review action and affect a practitioner's privileges for longer than 30 days. Entities must also report a practitioner who surrenders or otherwise voluntarily restricts their privileges while under investigation, relating to professional competence or conduct, or in return for forgoing such an investigation.[15]
- **Federal or State Health Care-Related Criminal Convictions.** Federal, state, and local prosecutors are required to report criminal convictions, regardless of pending appeals, related to the delivery of health care items or services against health care practitioners, providers, or suppliers.[16]
- **Health Care-Related Civil Judgments.** Federal and state attorneys as well as health plans are required to report civil judgments related to the delivery of health care items or services (regardless of pending appeals) against health care practitioners, providers, or suppliers.[17]
- **Exclusions from Participation in Federal or State Health Care Programs.** Federal agencies, state law enforcement agencies, state fraud control units, and state agencies (that administer or supervise state health care programs) must report health care practitioners, providers, or suppliers excluded from participating in federal or state health care programs.[18]
- **Other Adjudicated Actions or Decisions.** Federal government agencies, state law, or fraud enforcement agencies, and health plans, must report other adjudicated actions or decisions (such as limitations on scope of practice, exclusions, revocations, suspensions of license) related to the delivery, payment, or provision of a health care item or service against health care practitioners, providers, and suppliers.[19]

WHERE CAN I FIND MORE INFORMATION?

The *NPDB Guidebook* provides guidance and clarification on NPDB guidelines and policies. Published by HRSA, the latest edition of the *NPDB Guidebook* was released in April 2015. The *NPDB Guidebook* and other NPDB resources are available online at *www.npdb.hrsa.gov.*

Pursuant to policy passed at PAMED's October 2017 House of Delegates, PAMED will oppose any use of the NPDB to manipulate or dissuade physicians from application and participation on medical staffs. PAMED will also provide members with education on the NPDB and its dispute process.

PAMED is currently developing further NPDB resources for its member physicians. These resources include a module on the NPDB dispute process, discussion of steps that can be taken to mitigate the damage of an NPDB report, and education on how to respond to peer review proceedings. Look out for an article in the next issue of *Pennsylvania Physician* discussing the NPDB's dispute process.

Andrew C. Harvan, Esq., serves as PAMED's legal and regulatory analyst.

[12] 45 CFR §60.9-60.10 • [13] 45 CFR §60.11
[14] Id. • [15] 42 CFR §60.12 • [16] 45 CFR §60.13
[17] 45 CFR §60.14 • [18] 45 CFR §60.15
[19] 45 CFR §60.16

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FINANCIAL MANAGEMENT SERVICES SUPPORT FOR YOUR PRACTICE

New Program Lets You Focus on Patient Care

The Care Centered Collaborative, a subsidiary of PAMED, continues to create strategic partnerships, tools, and expertise so physicians can remain profitable and sustainable amidst the shifting health care marketplace.

The Collaborative's newest initiative includes management services organization (MSO) administrative services. Jaan Sidorov, MD, the Collaborative's CEO, sat down with *Pennsylvania Physician* to discuss why and how these services provide much-needed value to physician practices.

PP: *DR. SIDOROV, WHAT IS AN MSO AND WHAT SERVICES WILL YOURS OFFER?*

JS: A management services organization, or MSO, provides practice management and administrative support services to individual physicians and group practices. A primary purpose of an MSO is to relieve physicians of nonmedical business functions so they can concentrate on clinical aspects of their practice.

The Collaborative's program with its MSO partner, Formativ Health, will offer services related to revenue cycle, practice operations, finance and business operations, quality and care management, and service excellence. PAMED members will receive further discounts on the services offered.

PP: *WHY ARE MSO SERVICES A GOOD IDEA? WILL PHYSICIANS BE BETTER OFF?*

JS: MSOs generally achieve economies of scale, thus saving dollars for physicians on essential business services needed to successfully operate the physician's practice. MSOs have been able to develop outsourced billing to generate additional billings and a higher collection percentage, providing additional revenue to physician practices. The costs to the physician practice to use an outsourced system is generally less than the current billing system the practice may be using.

PP: ***TELL US HOW MSO SERVICES FIT WITHIN THE CARE CENTERED COLLABORATIVE'S STRATEGIC DIRECTION.***

JS: Value-based health care delivery and value-based contracting will continue to account for larger portions of practice revenue. Employers, payers, and, most importantly, patients are seeking greater value and transparency for the health care dollars spent. The linkage between measurable quality and cost reduction is how physicians are being judged.

Physicians need to adapt to be successful and sustainable. It is within this context the Care Centered Collaborative was created.

The Collaborative is evaluating and investing in partnerships that bring expertise to assist physicians during this transitional period. We're also using our clout to negotiate the highest quality services at the lowest cost (with additional discounts for PAMED members) to provide much-needed, hands-on support.

Like our successful MIPS registry reporting service, an MSO offering can now be utilized by practices seeking to improve both performance and overall success within the new reimbursement models.

PP: ***I UNDERSTAND THE COLLABORATIVE SELECTED FORMATIV HEALTH AS ITS CHOICE PARTNER FOR PENNSYLVANIA PHYSICIANS. WHY FORMATIV?***

JS: When the Collaborative was in its development phase, statewide survey feedback informed us as to the services in which Pennsylvania physicians were most interested. MSO services was in the Top 3.

Our COO Dennis Olmstead and CFO Bruce Roscher vetted numerous MSO companies and ultimately selected and contracted with Formativ Health. A national organization with a strong reputation, Formativ brings a wealth of experience — their MSO services enhance physician practices to improve financial health, adapt to changing risk-based payment models, and increase practice productivity and physician/patient satisfaction.

Formativ also put together for us a suite of three offerings for PAMED members.

PP: ***HOW WILL THESE TYPES OF SERVICES HELP PENNSYLVANIA PHYSICIANS SUCCEED WITHIN VALUE-BASED CARE MODELS?***

JS: The set of services being offered are designed to develop/improve practice efficiency, taking into consideration the current state of the practice related to shifting reimbursement models. As one of its first steps in working with physicians/practices, Formativ will conduct a free, comprehensive practice efficiency assessment.

Many of the "pain points" addressed by Formativ are foundational within value-based reimbursement models. Patient referral leakage, maximizing shared saving contracts, patient and provider satisfaction, expansion of care offerings, benchmarking and practice governance, addressing the increasing cost of administrative burdens, and, of course, maintaining and increasing cash flow and revenue.

Formativ's practice assessments are a good first step. They will help practices determine the level of need, and there is no obligation/no strings attached to do so.

PP: ***WHAT ELSE CAN PHYSICIANS LOOK FORWARD TO IN THE COLLABORATIVE PIPELINE?***

JS: One of the phrases I have become fond of is "we're bullish on physicians." In order to remain bullish, we must continually invest where health care and health care delivery is heading. We are currently ramping up our population health and data analytics capability, supporting the development of Clinically Integrated Networks (CINs), and creating care management programs for large practices and/or networks. Much of this work will be fully implemented this year.

OPTIONS FOR PHYSICIAN PRACTICES

Financial Management

- **Revenue Cycle Management Services**
  - Charge Capture
  - Performance Management
  - Payment Posting
  - Claims Management
  - A/R Follow-up (including Patient Responsibility)
  - Bad Debt Management
  - Patient Call and Inquiry Handling
- **Coding Feedback & Bi-Annual Audit**
- **Quality Review and Meeting with Front Desk Staff**

Financial Management with Enhanced Patient Experience

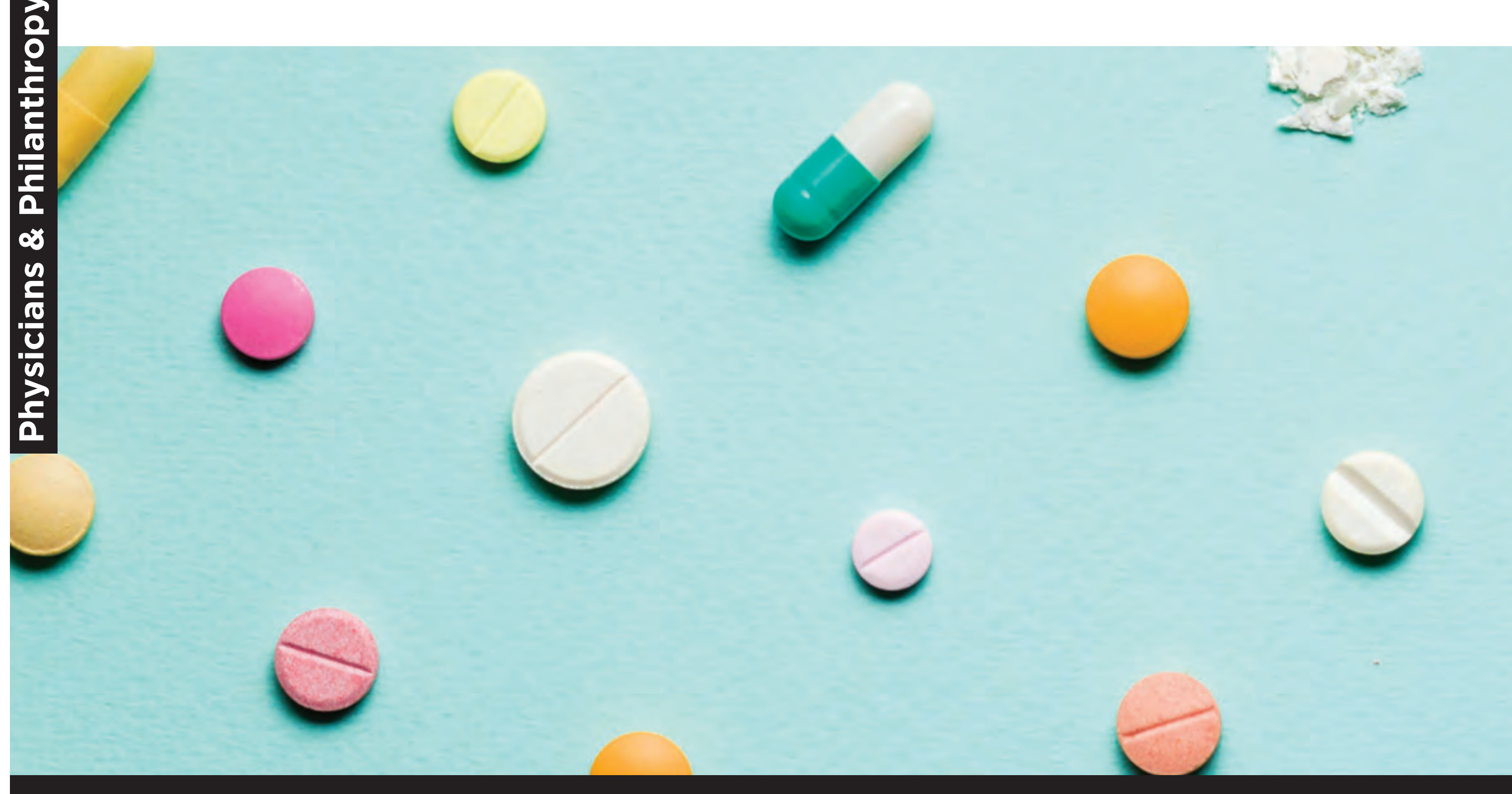
- **Financial Management Bundle**
- **Centralized Patient Access Registration**
- **Centralized Patient Access Scheduling**
- **Centralized Patient Access Insurance Eligibility**
- **Centralized Patient Access Pre-Authorization**
- **Centralized Patient Access Referral Management**

Financial Management with Operations Services

- **Financial Management Bundle**
- **Annual Practice Configuration & Financial Workflow Analysis**
- **Payer Enrollment Services**
- **Hospital Privileges and Provider Credentialing**
- **Human Resource Services**

Schedule your free practice efficiency assessment with Formativ Health.

Contact Anita Brazill, vice president of partnerships, at (570) 702-1152 or by email at *abrazill@patientccc.com*.



LIFEGUARD — YOUR SOLUTION FOR COMPLEX CHALLENGES IN HEALTH CARE

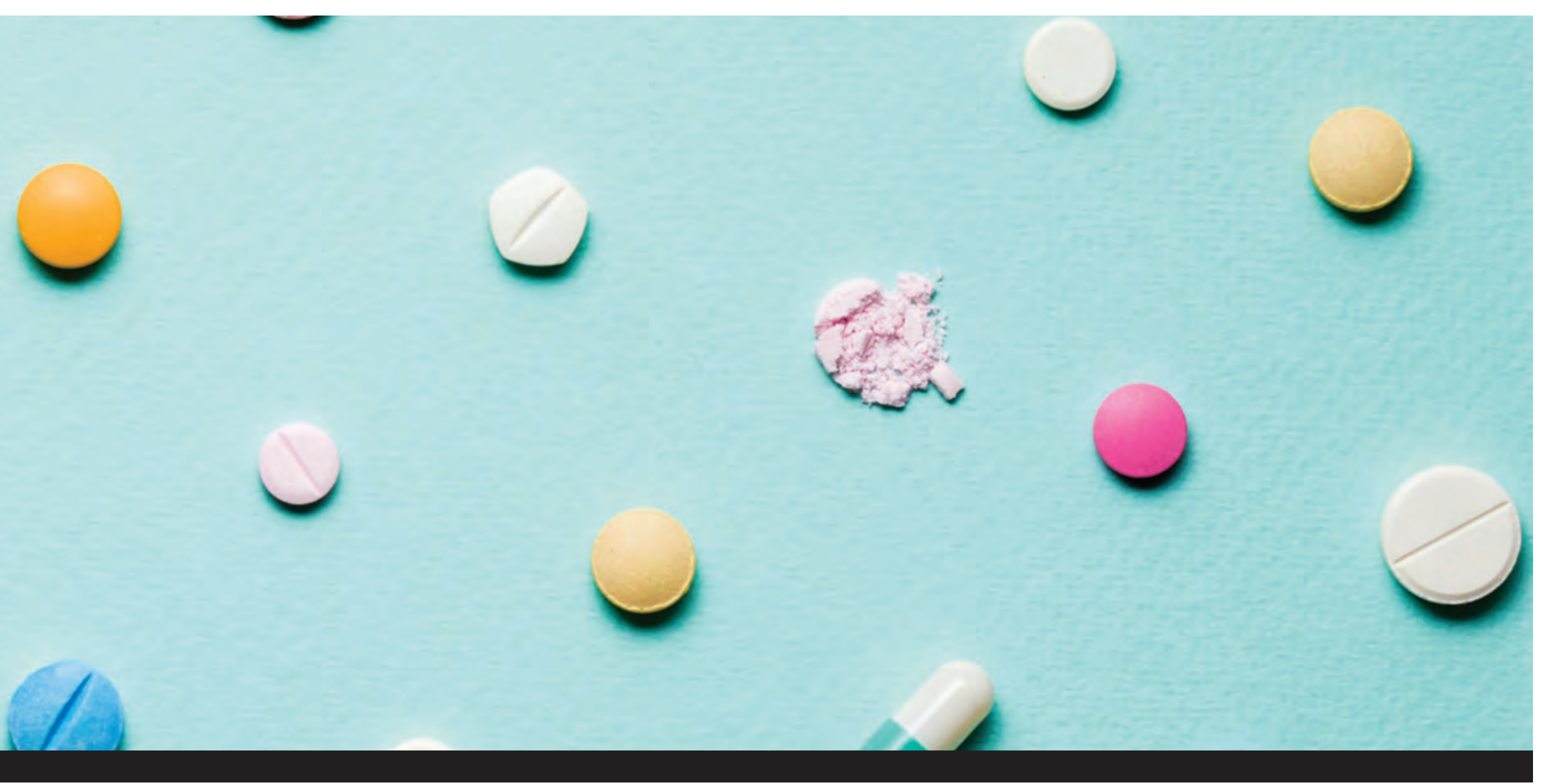
The Foundation of the Pennsylvania Medical Society LifeGuard program collaborates with nationwide experts to bring solutions to the complex issues facing health care providers. Experts have designed educational programs aimed to improve knowledge and immediately put skills into practice.

Every state is facing the opioid crisis. We all want our doctors to prescribe appropriately and prevent abuse. The difficulty for physicians is that they are the ones who are responsible for treating patients, but also the ones who can help alleviate the fallout of addiction. As the nationwide opioid crisis continues to escalate, officials are looking to state boards for guidance on addressing the multitude of factors that contribute to the problem.

The **Controlled Substance & Opioid Prescribing Educational Program** from nationally recognized LifeGuard provides a comprehensive educational experience led by experts in chronic pain management and addiction medicine. The course meets the criteria for education and training often recommended by state boards of medicine when a disciplinary action is indicated.

Participants will learn how to identify alternative pain management strategies that could potentially be abused and receive an update on recent changes in state law regarding prescriptive authority agreements. The course will also include a review of some of the optimal management practices for common sources of chronic pain, ways to improve patient adherence with medications, and more.

LifeGuard also offers practice monitoring to ensure that the learning has translated into practice modification within the physician's office.



The solution seems simple — stop overprescribing potentially addictive medications — but the problem is far more complex and requires education. Patients are not always forthcoming and may not provide all the facts to their physician. This can lead the physician to ask the wrong questions and write inaccurate treatment plans including prescribing inappropriately. Physicians cannot ask the right questions or decide on the right course of treatment without all of the facts.

Further, the problem extends beyond the drug itself. Once the prescription is issued, the physician must diligently manage the treatment of the patient. Without pain contracts and other treatment protocols in place, opioid misuse can easily fall under the radar. For physicians and practices seeking a proactive approach to ensuring that they are not contributing to the epidemic, continuing education is the best first step.

LifeGuard also partners with KSTAR, the similar program offered through the Rural & Community Health Institute at Texas A&M University, to offer a CME collaboration to physicians and other medical professionals. The course offering is designed to enhance knowledge and provide in-depth information on medical record maintenance.

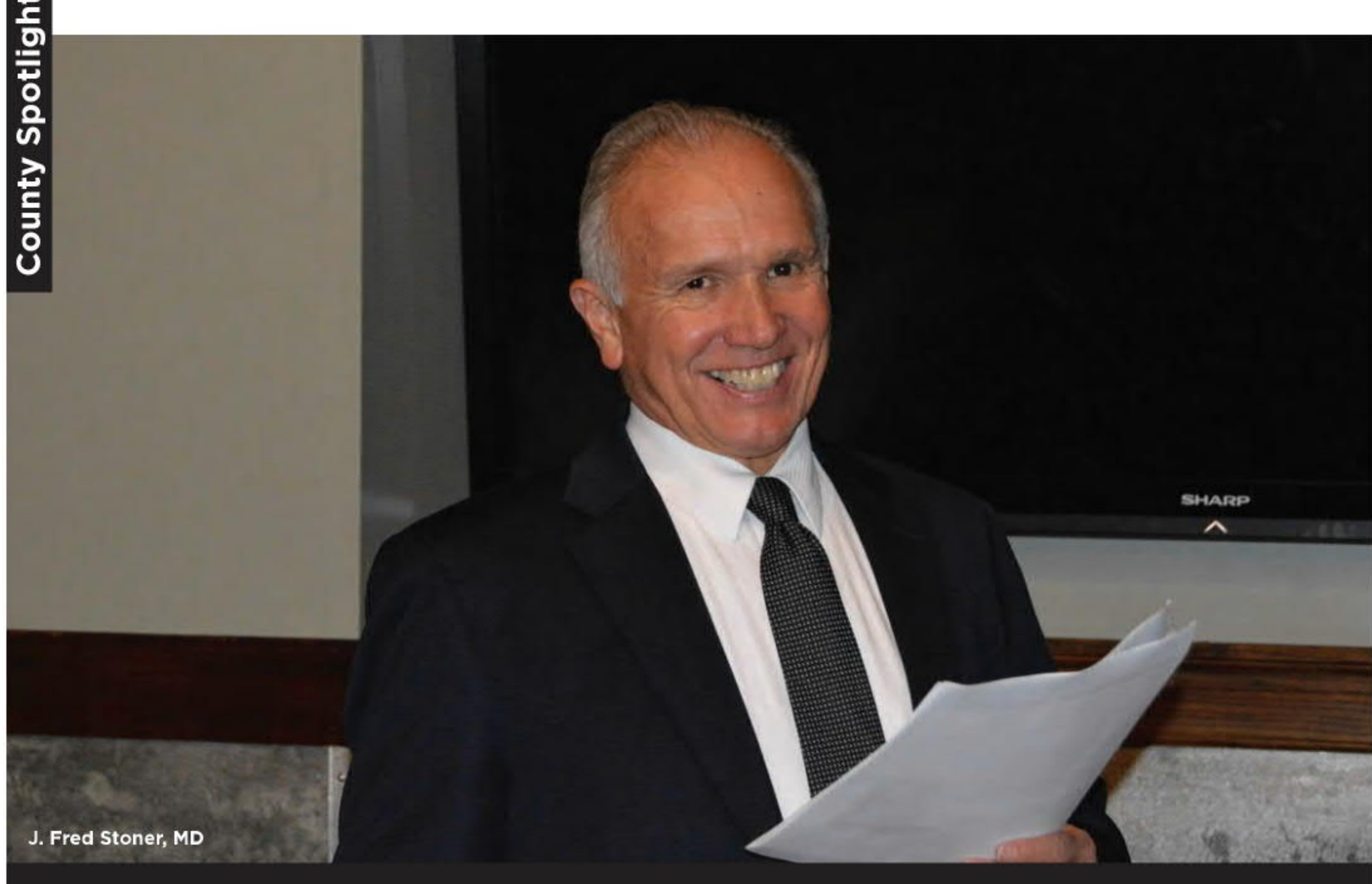
PHYSICIANS CANNOT ASK THE RIGHT QUESTIONS OR DECIDE ON THE RIGHT COURSE OF TREATMENT WITHOUT ALL OF THE FACTS.

LifeGuard Program Director Marcia Lammando, RN, BSN, MHSA, says, “This partnership offers a national educational program aimed at enhancing medical practice. Faculty will examine important topics from legal, regulatory, medical ethics, documentation, and prescribing challenges in today’s health care environment, and patient safety issues. Medical professionals will gain real-time, easily implemented knowledge for improvement through this course.”

Check out our website for the two-day **Medical Records CME Course** that will help participants improve their ability to maintain medical records efficiently and accurately. Attendees will learn how to keep records in a manner that improves quality of care, meets compliance standards, and reduces risk to the health care provider.

During the interactive course, attendees will learn how to identify potential pitfalls regarding documentation and use electronic health records more effectively. Once participants complete this course, they will have a thorough understanding of the legal implications associated with medical record documentation.

Find out more about LifeGuard’s CMEs and assessment programs at *www.lifeguardprogram.com.*



J. Fred Stoner, MD

LAWRENCE COUNTY MEDICAL SOCIETY TACKLES THE OPIOID CRISIS

When J. Fred Stoner, MD, a pain management and pathology physician, became president of the Lawrence County Medical Society, he recognized the need to address the opioid crisis in his own backyard. He was one of the initial planners of a pain, addiction, and law symposium (PALS) held in New Castle each year since 2011.

"I was born in New Castle, and I am a lifelong resident who practices here," says Dr. Stoner. "I wanted to find a way to help my community. Pain physicians are like soldiers in this civil war on opioids. We are in trenches being shot at from all angles. The best approach to this ongoing problem is public awareness through education."

The symposium, which offers CME and CLE, is geared toward anyone who can make a difference with the opioid crisis, including physicians, nurses, pharmacists, paramedics, judges, lawyers, industry staff, human resources, and law enforcement personnel.

Participants spend the entire day talking about prescribing opioids, trends, treatment, guidelines, medical management, and addiction. The course takes place in the spring. The Sixth Annual PALS was entitled "Opioid Crisis: Catch 22."

"America's problem with the opioid epidemic is still getting worse," says Dr. Stoner. "The CDC has recently given guidelines for prescribing opioids in the chronic pain patient: one should assess, manage, and monitor the patient. To reverse this epidemic, we need to improve the way in which we treat pain. We have to prevent abuse, addiction, and overdosing before it even starts. The opioid crisis is a catch 22: you're damned if you do and damned if you don't treat the chronic pain patient. Education is the solution. That is why we hold this important symposium."

"We are especially excited about our faculty who approach this problem with solutions and ways to manage the crisis. Everyone loves to hear Robert M. Stutman, who is the former head of the Drug Enforcement Agency in New York. He has made a 25-year career as one of America's highest profile drug busters," says Dr. Stoner.

> "TO REVERSE THIS EPIDEMIC, WE NEED TO IMPROVE THE WAY IN WHICH WE TREAT PAIN. WE HAVE TO PREVENT ABUSE, ADDICTION, AND OVERDOSING BEFORE IT EVEN STARTS."
>
> —J. FRED STONER, MD

His consulting firm now designs and implements comprehensive, practical substance abuse prevention programs for communities, corporations, and school systems across the nation.

"Everyone really responds to Bob's keynote," says Dr. Stoner. "His best-selling autobiography, *Dead on Delivery*, was the basis for a television movie entitled *Mob Justice*. He is really able to connect with the crowd to real-life solutions. Bob loves our symposium because of its uniqueness. It does not only focus on one group (e.g. health care professionals), but a diverse group that includes health care, law, police, educators, social workers, and drug and alcohol counselors, all together at one time."

Physicians who present at the symposium have seen thousands of cases come before them. Their goal is to make sure individuals receive appropriate therapy and assistance on their journey toward recovery.

Faculty member George Lloyd, MD, an addiction medicine specialist from Butler, serves on the Foundation of the Pennsylvania Medical Society's Physicians' Health Program (PHP) Advisory Committee. He is involved with participants and helps to report their progress in recovery. He says, "This symposium is a way to address the opioid crisis and provide real solutions to the problem. I'm there to champion programs like the PHP that offer monitoring programs to promote long-term success and recovery."

For more information on future symposiums, call (724) 658-6367.

For more information on the PHP, visit *www.foundationpamedsoc.org.*

A NEW FRONTIER FOR HEALTH CARE

PENNSYLVANIA PHYSICIANS EXPAND THEIR AUDIENCE THROUGH SOCIAL MEDIA

Just 15 years ago, physicians didn't have to think about having a social media presence. Facebook was founded in 2004, and Twitter launched two years later. Social media platforms — within a short window of time — have become a cultural force.

In response to the health care community's expanding use of social media, PAMED created a Social Media Ambassadors Program — an initiative that enables physicians and medical students to raise awareness about issues that affect patients and the practice of medicine in Pennsylvania.

We recently asked several PAMED Social Media Ambassadors about the opportunities that social media offers them.

"Social media provides a quick, easy method to share your thoughts. I like sharing my passions with my friends, including those that relate to my career as a family doctor," says Wendy Palastro, MD, a Pittsburgh-area family physician at Deer Lakes Medical.

Dr. Palastro sees potential in social media as more than just entertainment. "I love seeing adorable kids' photos, interesting selfies, and funny memes just as much as the next person, but I also feel social media is a useful way to broadcast your thoughts," she says. "It allows me to quickly and effectively get a message out to a much wider audience than I could ever reach in person. Going forward, I can see social media as a powerful way to educate others."

SOCIAL MEDIA PLATFORMS — WITHIN A SHORT WINDOW OF TIME — HAVE BECOME A CULTURAL FORCE.

Physicians like Alex Dressler, MD, an anesthesiology resident at the University of Pittsburgh Medical Center, also use social media to discover medical innovations.

"Social media allows me to connect to leaders and innovators in the field with whom I otherwise may not have the chance to interact," says Dr. Dressler. "It allows me to ask questions about research or new treatments directly to the people who are on the leading edge of the work. I often see research outcomes or recommended treatment changes on social media weeks or months before I see it published in a journal or practice advisory."

Family physician D. Scott McCracken, MD, FAWM, medical director of WellSpan Community Health Center in York, notes that social media lets him stay involved despite his busy schedule. "I have always been interested in engaging in the larger societal discussion about health care and medicine, but my time is limited and prevented me from writing review articles, editorials, or blogs on a regular basis," he says.

"Being a social media ambassador is a great way to leverage technology to engage with a larger audience, contribute to current conversations on health care policy and medicine, and advocate for physicians and public health, even if I only have a few minutes between seeing patients and getting the kids to soccer practice," says Dr. McCracken.

So, what will the social media landscape look like in another 15 years? Your guess is as good as ours, but one thing is certain — Physicians will be among those leading the charge, using these tools to advocate for colleagues and patients. ⬣

Find out how to become a PAMED Social Media Ambassador at *www.pamedsoc.org/socialmedia*.

Are You a PAMED Member for 2018?

There's still time to renew or join for 2018. Current members can renew online at *www.pamedsoc.org/renew*.

To join, visit *JoinNow.pamedsoc.org* or call our Knowledge Center at 855-PAMED4U (855-726-3348).

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Edward (Ted) Stephenson, MD

CLINICAL INTERESTS: Heart valve repair and replacement, coronary artery bypass, thoracic aortic surgery, left ventricular assist device, heart transplant and transcatheter aortic valve replacement

Kentaro Yamane, MD

CLINICAL INTERESTS: Coronary artery bypass surgery, heart valve surgery, aortic root surgery, minimally invasive cardiac surgery, complex adult cardiac surgery, transcatheter aortic valve replacement, transcatheter mitral valve replacement, aortic surgery, heart transplant and ventricular assist device

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CALENDAR OF EVENTS

LEARN ABOUT UPCOMING EVENTS

Foundation of the Pennsylvania Medical Society LifeGuard CMEs

Controlled Substance and Opioid Prescribing Educational Course

- **May 3 - 4**
- **Nov. 15 - 16**

Medical Records Course

- **May 14 - 15**
- **Oct. 29 - 30**

Learn more and register at *www.lifeguardprogram.com.*

2018 PAMED Board of Trustees Meetings

- **Feb. 6 - 7** PAMED Headquarters, Harrisburg
- **May 8 - 9** PAMED Headquarters, Harrisburg
- **Aug. 14 - 15** PAMED Headquarters, Harrisburg
- **Oct. 26 & 28** Hershey Lodge, in conjunction with PAMED's 2018 House of Delegates

CMO and Senior-Level Physician Leaders Series

For CMOs, VPs, Chiefs of Medical Staff, Practice Partners/Owners, etc.

PAMED Headquarters in Harrisburg

- **March 23** Two Hats, One Team: Challenges Associated with the Dual Roles of Administrator and Clinician
- **April 27** Health Care Consolidation: Impact on Physician Executives
- **May 18** Influential Presentations
- **June 15** IT Solutions for Future Health Care Systems
- **July 13** Enlightened Leadership and Change Management
- **Aug. 17** Managing Virtual Teams

www.pamedsoc.org/PhysicianLeaders.

Practice Administrator Leadership Development Training (New!)

PAMED Headquarters, Harrisburg

- **May 24** Communication Strategies
- **July 19** Strategic Thinking and Decision Making
- **Sept. 13** Employee Engagement/ Performance Management

www.pamedsoc.org/ PracticeAdminLeadership.

2018-2019 Year-Round Leadership Academy

Sept. 1, 2018 – June 30, 2019

In-person and online courses

Watch for more information coming soon at *www.pamedsoc.org/YRA.* Scholarships will be available.

Spring Practice Administrator Meetings

April 24, 1-3 pm

- Hilton Garden Inn Pittsburgh Cranberry *Registration and lunch at Noon*

May 10, 1-3 pm

- Doylestown Health and Wellness Center *Registration and lunch at Noon*

May 15, 8:30-11 am

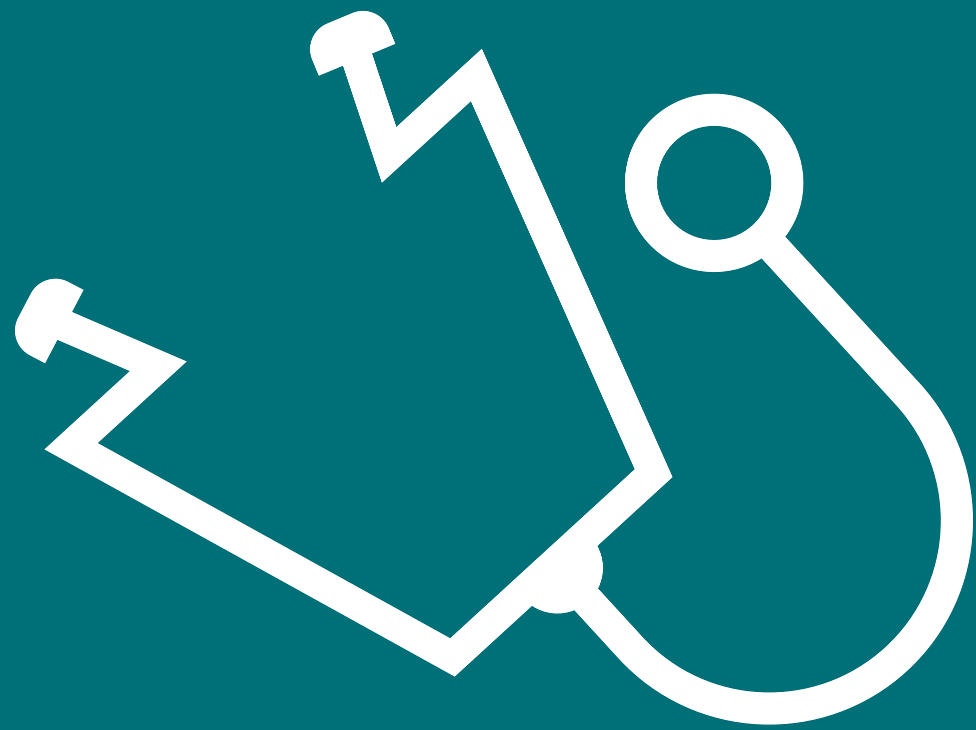
- PAMED Headquarters, Harrisburg (Plus live webcast) *Registration and breakfast at 7:45 am*

www.pamedsoc.org/ManagerMeeting

2018 Advocacy Day

May 22

www.pamedsoc.org/AdvocacyDay



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173,285
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138 PEOPLE
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This project is being funded by a grant received from the Pennsylvania Department of Health.