Onward and upward! 
BY JAMES G. (JIM) BECKNER
Executive Director

Summer is often thought of as a time when life slows a bit, when minds turn to walks on mountain trails, fun in the surf or road trips to distant places. Such idyllic, slowed-paced summers were indeed a reality a few decades ago when I was growing up in the Valley of Virginia. School was out and summer meant longer days with less structure. Demands and expectations on us no longer were there such things as slower times or off periods. Demands and expectations on us no longer ebb and flow — now there’s just flow! The new reality is that we now have only peak times, and greater peak times.

And in July, for the first time, your board of trustees welcomed VCU interns, residents and fellows to the Richmond medical community at a RAM-sponsored social. Our event was held at Richmond’s own Hardywood Brewery. At this event, we learned that there’s nothing like craft beer and barbecue to bring out house staff! The turnout was exceptional and gave the Academy an exciting opportunity to meet with these young physicians, talk about organized medicine and to encourage their involvement with RAM.

After our kids returned to school last month, we got back to what I like to call RAM’s annual “busy time.” Our September meeting was highlighted by the appearance of Lt. Gov. Ralph Northam, MD. We appreciated Dr. Northam’s timely thoughts on a variety of issues, including moving from a “quantity-based” system of physician reimbursements toward an outcome-based system. And his remarks on medical school costs could not have been more timely for the Academy!

For many of us, medical school tuition is a distant memory, but the cost of medical education has increased dramatically. For the academic year 2014-15, in-state tuition at VCU was $29,100, exclusive of books and room and board. The good news is that number remains.

Busy (and exciting) times at the Academy
BY PETER A. ZEDLER, MD

It’s hard to believe that it is already the fall! I hope you managed to find some time to relax over the summer. While summertime tends to be a slow time for many of us, your Academy hosted its annual Family Night social at Lewis Ginter Botanical Garden. Perfect weather, music, hamburgers and hot dogs with lots of happy kids allowed our members to interact with each other and just have fun.

And in July, for the first time, your board of trustees welcomed VCU interns, residents and fellows to the Richmond medical community at a RAM-sponsored social. Our event was held at Richmond’s own Hardywood Brewery. At this event, we learned that there’s nothing like craft beer and barbecue to bring out house staff! The turnout was exceptional and gave the Academy an exciting opportunity to meet with these young physicians, talk about organized medicine and to encourage their involvement with RAM.

After our kids returned to school last month, we got back to what I like to call RAM’s annual “busy time.”

Our September meeting was highlighted by the appearance of Lt. Gov. Ralph Northam, MD. We appreciated Dr. Northam’s timely thoughts on a variety of issues, including moving from a “quantity-based” system of physician reimbursements toward an outcome-based system. And his remarks on medical school costs could not have been more timely for the Academy!

For many of us, medical school tuition is a distant memory, but the cost of medical education has increased dramatically. For the academic year 2014-15, in-state tuition at VCU was $29,100, exclusive of books and room and board. The good news is that number remains.

Why we join and why it matters
BY ISAAC L. WORMAN III, MD, FACOOG

Before anyone coined the term “multitasking,” most physicians I know were pretty darn good at that as well as a related skill that you might call “multi-joining.” My own multifaceted membership history goes way back to the early 1960s, when I joined the First Baptist Church in downtown Newport News.

I was 7 years old at the time and, as I remember it, my primary motivation was a desire to participate in communion and get the little piece of bread and drink the grape juice which you couldn’t do unless you were a baptized member of the church. I have certainly come to understand that being a member of a Christian church means much more than that. Second Baptist Church in Richmond has been a huge part of my life and my family’s life for 26 years. My friends there helped Susan and I raise our family, and they have been there for us through the good and the bad. Those of us who belong to religious groups know how this can be.

Professional organizations such as RAM are not like religious groups. That is, generally speaking they’re not held together by faith or core beliefs. I would hasten to add that all physicians are bound by a common interest in healing the sick among us. Many of us took the Hippocratic Oath as a manifestation of that common interest at some point in our lives.

Medical societies such as RAM do bring together busy “men,” continued on page 2

Why medicine matters to me
OPENING THE DOOR OF PATIENTS PORTALS
WINNING THE BATTLE FOR INSURANCE REFORM
below the median cost of $33,000 for public medical schools across the U.S. While VCU has done a good job at keeping that tuition number as flat as possible, the cost remains high for each and every aspiring physician. On a national basis, the cost of attending four years of public medical school is an astonishing high of $167,000, and for students wishing to attend private medical schools the cost soars even higher.

About a third of all students come to med school already weighed down with an average debt of $20,000 from their undergraduate studies. Thus, by the time they finished medical school last year, the average debt nationally was $167,000 for students at public universities. Interest rates on these student loans were very generous, either, hovering between 5.4 and 6.4 percent.

Though these numbers are scary, they still have not deterred exceptionally bright and dedicated students from pursuing careers in medicine. Class size continues to grow. But these cold hard numbers are known to have a big impact on how this emerging generation of talented physicians chooses to practice medicine. The high cost of medical education and its associated indebtedness will reduce the number of doctors entering areas of primary care or choosing to live in rural communities that desperately need an infusion of skills from these individuals.

Solutions to this vexing issue are complex and will necessarily involve many interested parties. At the Academy, with our partner the Medical Society of Virginia, we welcome the discussion and seek ways to keep educational costs low so that newly-minted doctors who wish to pursue careers in primary care do not face economic disincentives. Of course, as the saying goes, “talk is cheap.” So at our September meeting, I announced a small but significant step that your Academy has taken to address the problem. The Richmond Academy Trust and the RAM board of trustees approved the establishment of a new Richmond Academy of Medicine Endowed Scholarship, with a financial commitment of $100,000 from the RAM Trust.

A committee of the board, along with former RAM President Wyatt S. Beazley III, MD, met with VCU’s development office to establish our new endowment and develop the job criteria for choosing recipients of the scholarship. The first recipient will be announced in the fall of 2016 and will be chosen with the aid of the VCU development office. To be eligible, our scholar will be starting his or her second year of study; hail from Central Virginia; be in the top half of his or her medical school class; and have shown demonstrable interest in organized medicine and community service. The level of financial need will be determined by VCU. An endowment of $100,000 will generate about $4,500 a year and will be available for our student for the final three years of school. Yes, this may seem like a drop in the bucket when looking at a mountain of debt, but it’s a significant start. We expect that the endowment with VCU will continue for many decades to come, and we hope this scholarship fund will continue to grow from the generosity of our members. Thus, larger grants may be available to more students in the future.

Many of our members have affiliations with MCV (I know, VCU) and are already making significant contributions in their own way. To you I extend a sincere “Thank You!” And some of you may already be giving to another alma mater elsewhere. Other ideas and putting them into a legislative format and debating them within the Academy before bringing them to the annual meeting of the Medical Society of Virginia later this month. Some of these proposals will find legislative sponsors and will be introduced as potential bills. I hope to see many of you at our “2016 White Coat Day” events to meet state legislators to let them know — face to face — your concerns.

Dr. Northam’s recent speech addressed one of our upcoming legislative initiatives — that is, the limited number of residency slots available to graduating medical students. Funding for these positions comes primarily from the federal government via Medicare. That funding has been fixed for many years.

Look for RAM to join MSV in urging the General Assembly to pass legislation that will make medical school education more affordable and available to our many gifted young students in the Old Dominion.

All of these ideas, initiatives and funding decisions are a reflection of our members’ interests. I look forward to seeing you at upcoming events and hearing more great ideas and ways you wish to be involved as your Academy continues to fulfill its core mission — “to be the patient’s advocate, the physician’s ally, and the community’s partner.”

Let’s talk about ways you want to become involved in the many exciting initiatives that you make possible!
“Onward,” continued from page 1

hosted which more than doubled Academy membership for those groups. Maybe you attended the wonderful annual family picnic in July at Lewis Center Botanical Garden that drew about 200 provi- goers with RAM members and their families.

• Honoring Choices® Virginia trained 32 new facilitators and helped establish 9 more advance care planning centers in all three of our local major health systems, bringing the total to 18. An extensive search was conducted and a permanent Program Director — Robin C. Cummings — was hired to take HCV to ever greater heights.

• Access Now successfully completed a highly competitive grant process and was chosen to be part of the United Way of Greater Richmond and Petersburg family of funded agencies.

• RAM Services Corporation planned and implemented a number of statewide conferences, such as the Virginia Chapter of the American College of Radiology’s annual meeting, the Virginia Chapter of the American Academy of Pediatrics’ Art and Business Conference; and a joint meeting on Virginia Maternity Care sponsored by the Virginia Chapter of the American Academy of Pediatrics along with the Centers for Disease Control and Prevention (CDC) and the Virginia Department of Health.

• Centralized Credentials Verification Service (CCVS) achieved accredit- ation by the National Commit- tee for Quality Assurance (NCQA) with an amazing score of 98.6 (out of 100)!

• Internally, the Academy restructured its finance department, hired a full-time bookkeeper, and engaged Cyndy Lowery from the firm of Warren Whitney to strengthen our internal financial controls and bring us to the level of industry best practice.

The coming, cooler months promise even more activity — and that’s where you come in. You are needed more than ever! As Dr. Isaac Wornom writes elsewhere in this issue, Get Involved! We know your time is precious, so please look for the place in the Academy that speaks to you.

Find your touch point. Seize your passion and join your peers in moving the Richmond Academy of Medicine onward and upward!

And most importantly, I want to thank you for all you have done and continue to do to make RAM the patient’s advocate, the physician’s ally and the community’s partner.

“Join,” continued from page 1

practitioners who are bound by com- mon interests. These include opportu- nities to improve oneself through education, a chance to provide service and legislative advocacy. Some years ago, when I first joined the Academy, I heard then-President John O’Bannon say that RAM provided everything a doctor needed to practice medicine in Richmond at that time: “a dictation number and a parking card for the hospitals!”

Today, of course, I’m sure my friend Dr. O’Bannon — now a distin- guished member of Virginia’s House of Delegates — would agree that the 21st century version of RAM certainly offers more than dictation numbers and parking cards. And yet as I reflect on my 26 years as a member, I’m struck by how its service components remain a tie that binds area physi- cians. Where would we be without our very own Centralized Credentials Verification Service that many of us use to maintain our hospital privi- leges? How would the free clinics of Central Virginia be able to care for their many patients who need special- ty care without Access Now? Where would the important conversations about end-of-life issues have begun and moved forward without RAM leading the way through Honoring Choices® Virginia?

RAM is certainly more than several dinner meetings a year when the doctors of Central Virginia get together to eat, socialize and hear a speaker. Yet, I also don’t think we should discount the importance of these gatherings. They are perhaps the only time when the doctors from our three competitive health systems and those of us who are in private practice can come together as a group in a collegial manner. In fact, RAM is the only bridge that exists between these physician groups, which makes its existence and growth even more vital. This struck me years ago when I would sit in RAM board meetings with doctors from various groups. It amazed me how many of our concerns were so similar.

One of the things I have learned about all organizations is the more you give to them the more you get out of them. The corollary to this is the quote from that well-known, but highly flawed, philosopher Woody Allen who’s known for saying, “80 percent of success is showing up.”

We show up for what we value and see as important. For many years now, professional, civic and service organizations around the nation have seen sharp declines in member- ship and participation. This has been ascribed to the differences between baby boomers who tended to be join- ers and those millennials who have their own way of making choices. My own kids are still trying to explain this to me, but I’ve been told it has to do with having a “purpose- driven sensibility.” If an organization can demonstrate real purpose and meaning to the young among us, it will grow and prosper.

Over the past decade, RAM has managed to buck the trend of de- clines in membership in professional organizations. This says something about the vibrancy and relevance of RAM.

With HDJN on your side, you have one of the nation’s most experienced healthcare law firms as your advocate, thought partner and trusted advisor.

We help you identify and execute opportunities to meet business objectives.

Our highly specialized experts provide timely, practical solutions that serve the unique needs of healthcare providers and healthcare companies in a cost-effective manner. We can help you mitigate risk and maintain a viable business with comprehensive legal support.

Dr. Wornom practices at Richmond Plastic Surgeons and is the editor of Ramifications. He can be reached at wournom@richmondplasticsurgons.com.
Patient portals: The good, the bad and the (potentially) ugly

It’s clear that patients want to monitor their health, wearing those ubiquitous fitness trackers and keeping track of their habits via smartphone apps.

This kind of enthusiasm for patient engagement should bode well for patient portals, which typically allow them to view their record, share information and contact physicians. Christine Bechtel, a consultant for the National Partnership for Women and Families, recently told the Wall Street Journal, “For consumers to start requesting and using their health information will be a game-changer for the healthcare system.”

Yet, getting patients to sign up for these portals hasn’t been easy. That might not be a bad thing, though, because once a practice opens its virtual doors, there’s no telling who’s going to come in.

The government — not exactly known for its online security in the wake of recent high-profile breaches — wants physicians to have these open doors and ties use to reimbursement.

The American Recovery and Reinvestment Act of 2009 included money to incentivize physicians and hospitals to move to electronic health records. While Stage 1 did not require a patient portal, the second stage stipulated that a minimum of 5 percent of patients — not just Medicare, but all patients — had to view, download or transmit their medical records via the portal and 5 percent had to communicate with their physician via secure messaging, explained Robert Tennant, director, HIT Policy at the Medical Group Management Association (MGMA). “These were stumbling blocks, not just for the practices, but also for hospitals and vendors, who were struggling to implement these portals.”

Earlier this year, the government issued the Meaningful Use Stage 3 proposed rule, requiring practices to increase the threshold on patient portal usage to 25 percent of patients and 35 percent for secure messaging. In their official comments to the government, physicians’ groups such as the American Medical Association and MGMA have pushed back on these higher thresholds and have called on the government to delay this final stage of the program. Congress is even getting into the act with legislation recently introduced by Rep. Renee Ellmers (R-North Carolina) to improve Stage 2 and delay Stage 3.

The delay caused an outcry from patient advocacy groups eager to see more “consumer-friendly” policies. Still, most practices continued their initiatives to get more patients in the portal pipeline. It may not be a mar-

These were stumbling blocks, not just for the practices, but also for hospitals and vendors, who were struggling to implement these portals.
A proposed regulation is written. “For family practice, pediatrics, internal medicine or geriatrics, you can see the importance of a portal, but they may not be a good fit for other specialties,” Tennant said. “Many patients are looking to leverage portals to access scheduling and billing data and want to have the ability to complete administrative forms prior to the visit. Unfortunately, the current regulations do not permit these tasks to be counted toward meeting the requirements. The government has missed an opportunity to encourage the use of portals by both practices and their patients.”

Like so many federal mandates, the problem is the one-size-fits-all approach. Physicians and practice administrators often get tired of trying to find a reasonable way to comply without losing their autonomy.

The rules are the same for all practices, whether a busy primary care or a specialist a patient might see once. Susan Hickey, CEO at Virginia Ear, Nose & Throat, is baffled. “It doesn’t make sense for the criteria to be the same for everybody. A large portion of our patients have acute problems. Once the problems are resolved, these patients have no reason to communicate with us via a patient portal or other means. Conversely, patients have the same primary care providers for years.”

Hickey is actually a supporter of patient portals and said the practice has found them to be useful tools. Virginia Ear, Nose & Throat was an early adopter of electronic health records and patient portals. Kim West, business office director at the practice, said having the online payment feature in the portal has been helpful to the practice. “It’s one way all practices can get people to log in.”

Portals can be convenient for patients. But is the convenience worth it for physicians? It takes a lot of dedicated manpower and busy private practices don’t usually have that in excess.

The cost can be prohibitive, Tennant said. “The workflow around this patient portal, getting this information up and available, is very complicated. And it can be costly if the practice is forced to do it on an expedited basis.”

“A lot of practices are asking if it’s really worth it,” he said. “They’re not convinced that patients really are clamoring for this online access. Again, if you think about it as a patient and ask why you’d go online, you’re probably thinking about scheduling an appointment, not looking at medical records.”

It also requires a lot of buy-in from patients. The reality of patient engagement means that having multiple portals for each patient requires a lot of logins and passwords to remember. Since there are no standards for interaction, patients may be receiving unsecured emails, snail mail or other forms of contact from practices.

Patient portals are just that — not a data breach

Preventing a data breach

So what other data protection methods can you exercise? There are several steps and precautions your practice can take, including:

• Adhere to the National Institute of Standards and Technology’s (NIST) Risk Management Framework to evaluate all IT systems containing personal health information at your practice and ensure they’re in accordance with HIPAA standards.

• Adhere to the HIPAA-compliant NIST, International Organization for Standardization and Health Information Trust Alliance standards when formulating an EHR security protection program.

• Divide patient and guest data in an attempt to keep networks secure.

• Consider giving administrators login and authentication on computers and networks at your practice, including controlling access and validating privileges.

• Learn to dispose of computer equipment properly.

Source: Ahmed Mori, PowerYourPractice.com
doorways into your practice. And you can’t always see who’s at the door. Your patients may be well-meaning but you can’t guarantee that their online security is adequate. Further, many practices simply cannot afford the sophisticated infrastructure and IT security required to protect their computers. With today’s mobile technology, it’s easy for a smartphone or tablet (patient’s or physician’s) to fall into the wrong hands, possibly even overseas. Emerging technology, it seems, outpaces federal regulations.

“More technology means a practice needs to dedicate more resources to policing its computers,” said Ed Winfree, a “white-hat” computer expert who works with several area medical practices. As a white-hat hacker, Winfree specializes in ethical hacking such as penetration testing to measure a company’s Internet security. He has seen a lot of computer system breaches — some with devastating consequences.

At a time when millions of Anthem subscribers’ data can be breached, the potential for patient data loss is every physician’s and practice manager’s worst nightmare. Many breaches are just standard phishing schemes, looking for information. Others are hoping to grab credit card information, others just to disrupt business as usual. Winfree recalls a medical practice out of state that was hacked. “No data was stolen,” he said. “They were hacked because their server was heavy-duty enough to be a game server for Call of Duty. The hackers got in, loaded software and started running it. It was found a few days later when there were processes running that shouldn’t have been.”

A security breach may not be noticed right away, he said, and the only clue could be something as small as a computer mouse not working. “There are a whole bunch of different attacks you can do,” Winfree said. “And a lot of portals are working on the cloud variant. People need to understand that all clouds rain sometimes.”

The website Power Your Practice wrote, “While this influx of digital data is great for improving health care, it ups the ante for hackers and thieves to steal valuable personal health information …. Healthcare organizations need to act as their own watchdogs, so to speak, to protect their patients — and themselves — from the dangers of a data breach.”

“It’s not just the data. It’s the

---

**Portal,” continued from page 5**

The MitraClip is a big idea wrapped in a small package that’s giving patients all over Central Virginia a new outlook on life. Designed to solve a problem for high-risk patients diagnosed with mitral valve regurgitation, the MitraClip is a minimally invasive solution, and it’s only available at the Advanced Cardiac Valve Center at the Bon Secours Heart & Vascular Institute. Our expert team is led by cardiovascular pioneer Dr. Marc Katz, in partnership with Dr. Scott Lim from University of Virginia Health System. Together, they are the first to bring this amazing medical innovation to Virginia to treat those with mitral valve disease.

To learn more, visit acvcmoh.com
To refer a patient, call 804-287-7840

ADVANCED CARDIAC VALVE CENTER
fallout because a patient’s Yahoo or Facebook account gets hacked,” said Lucien Roberts, administrator at Gastrointestinal Specialists Inc. “It’s not going to be Yahoo or Facebook who get the black eye from this. It will be us.”

Earlier this year, the Anthem hacking incident sent widespread shudders through the healthcare world. “The Anthem data breach, along with other highly publicized cases like Sony and Target, tells us that corporate information systems are fighting a losing battle against hackers. Health care, in particular, could be especially vulnerable,” wrote Paddy Padmanabham on the website CIO. “The incident affected a relatively small number of individuals, but it was nevertheless significant that one of the largest health systems in the country could not prevent these incidents. Where does that leave relatively smaller health systems that are struggling to survive and cannot afford to invest in the kind of state-of-the-art infrastructure that can protect their environments from cyber attacks?”

What’s a practice to do?

The first thing to do is for a practice to determine if it’s even worth moving on to Stage 2 of Meaningful Use versus paying the penalties for non-participation, said MGMA’s Tennant.

“If the practice does move forward with deployment of a portal, depending on the finances of the practice, you may want to invest in hiring a security consultant to ensure its security.”

Winfree stresses that it’s essential to know the exact configuration of a practice’s computers, software and hardware, which makes it easier to track and eliminate threats.

And if a breach is suspected, by law you must act quickly to secure the data and notify the affected patients. “Any practice that does not have its own internal IT staff should let administrator and principals know where the Internet kill switch is,” Winfree said. “If you feel you’re getting hacked, do not have any hesitation to pull that switch. It would be much better to deny service to those trying to get in than to let one bad guy in and lose everything.”

“Yes, you’ll be down. But would you rather be down and out?”

Lisa Crutchfield is Richmond-based freelance writer.

---

1. Direct patients to access return to work or school slips on the portal.
   This tip even works for say general or orthopedic surgeons who see many patients one time — maybe — for follow-up.

2. Get tablets and train on-site.
   Have a staff member walk patients through signing into the portal and sending a message to the nursing staff, letting them know why they are in the clinic today. This is a “teachable moment” for patients and can be done in the waiting area or exam rooms while patients are waiting to see the provider.

3. Promote it.
   Most patients would find a portal quite useful, if they knew it was there, what it was, and how it benefits them. Make sure when marketing your portal that you are letting patients know they can send and receive messages from the staff, check lab results, and request refills without waiting for call-backs.

4. Get the doctors in on it.
   This works in two ways. First, have doctors talk with patients about it, even if it’s simply letting them know when their prescription runs out they can request a refill via the portal or to check for their lab results. You can also have the physician ask patients to check for a message from the clinic to see how they are doing after the visit.

Source: Physician’s Practice By Audrey “Christie” Mclaughlin, RN, who spoke at the Practice Management Institute Conference in May, 2015.

---

64% Percentage of Americans who don’t currently use online patient portals.

57% Percentage that would be much more interested and proactive in their personal healthcare if they had online access to their medical records.

35% Percentage didn’t know a portal was available.

31% Percentage said their physician had never spoken to them about portals.

Source: Xerox annual EHR survey
REACH A WIDER PATIENT BASE WITH A MORE CONVENIENT LOCATION

Whether coming from Ashland or Chesterfield, Mechanicsville or Midlothian, West Creek Medical Park is easy to access from anywhere in central Virginia. Patient drop-off and pick-up are a breeze at this state-of-the-art, Class A medical office space, and there’s plenty of parking for everyone. Take your practice to the next level. Contact David M. Smith today for leasing information.

Lease today. 804-697-3466 or david.smith@thalhimer.com

The MEDARVA Low Vision Center, central Virginia’s only full-time private low vision rehabilitation center, welcomes Dr. Suzanne Kim.

Suzanne Kim, O.D. | Approved State Low Vision Provider

As the Director of the MEDARVA Low Vision Center, Dr. Kim is committed to providing low vision care to people with visual impairment in order to maximize their remaining usable vision and allow them to regain independence in activities of daily living.

Improving quality of life and independence for people with vision impairments since 1997.

8700 Stony Point Parkway, Suite 100 | Richmond, VA 23235 | (804) 545-9435 | www.LowVisionVA.com
Why medicine matters to me

BY ANNE BYRD MAHONEY

Every morning I wake up to the sound of my roommate and fellow classmate’s feet hitting the floor in the bedroom above mine. Inevitably, I have slept through my alarm in denial of my 6:30 a.m. wake-up call and the many hours of class that lie ahead. Only when her feet touch the floor do I know that, without a doubt, it is time for me to start my day. I jump from my bed, dress in a hurry and grab a granola bar from the kitchen before racing out to the car where my roommate is already waiting.

But as we make the 20-minute commute to campus, I start to wake up and a small wave of excitement goes through me. Each day, the reality that I get to learn and be a part of medicine gives me a jolt of energy that’s more powerful than anything I might buy at Starbucks. Being a medical student at VCU’s School of Medicine is an opportunity that is worth it.

A bit of background is in order: When I was growing up, I was not interested in medicine as a profession. My mom and dad will attest to the fact that it was torture for them to bring me the doctor’s office. (This is all the more ironic since my mom is a doctor herself, and you’d think I could be a little more trusting!) I can remember screaming and crying when the nurse asked me to read the eye exam chart, thinking that if I stalled long enough I wouldn’t have to get a shot at the end of my visit.

Later, I found languages to be easier in school and always shied away from the science and math courses that are a prerequisite for applying to medical school. My drift away from medicine ended during my senior year of high school when I got the opportunity to shadow a heart surgeon and a family practice doctor for two weeks. I walked away from those experiences hooked and remained so through my four years of college. Though I loved all of my pre-med classes as an undergraduate, it’s exciting to think that what I’m learning now at VCU will one day be directly applicable to my practice as a physician. Most days that excitement alone is as effective as a double cappuccino.

However, there are definitely days that require multiple cups of actual, nonmetaphorical coffee. Medical school is the hardest thing I’ve ever done, and I would be remiss to not portray it as such. Not only is the material complex, tedious and, quite frankly, time-consuming to master, but the environment can be rife with anxiety. The pressure to do well is palpable around exam time, as we all want to achieve the highest levels of success. This pressure to succeed is amplified by the fact that our national medical environment is changing.

More and more medical schools, like VCU, are accepting larger classes while residency programs are not expanding. Also, the uncertainty surrounding the Affordable Care Act and how it will affect the practice of medicine when we graduate weighs on us as we attempt to plan for our futures, not only as physicians but as family members and spouses.

The amount of debt medical students are graduating with is at a record high — averaging more than $151,000 for members of the VCU School of Medicine’s Class of 2014. (It’s worth noting that as bad as that was for VCU’s medical school graduates — some 91 percent of whom carried debt — the average debt load was actually less than the national average for other students at public medical schools, $167,000. But even with VCU’s better-than-average showing, this debt load can be especially daunting if one chooses to enter into a lower paying medical specialty.

This summer I was fortunate to travel to Peru and work in a medical clinic for two weeks. My experience there made me realize that all of the tough days in medical school are worth it. Every second spent scrutinizing the minute details of human physiology or of mechanisms of action of this and that drug is worth it. Any uncertainty about what lies ahead was negated by the passion I felt while working with patients. I didn’t need the sound of my roommate’s feet to wake me up while in Peru. I woke up every day excited to spend time with patients and to learn more about how to treat them. I left Peru knowing full well that I have much more to learn and wanting to be of more value to patients.

Completing my first year of medical school has helped me to not worry as much about what lies ahead. As I continue to explore the kind of doctor I want to be — both through learning in the classroom this year and by making rounds next year — I will focus most on what is under my control.

I’ve learned that no matter what happens to medicine in the future, I have the resources and passion to be the best physician I can be. Medicine is a discipline that requires constant learning and vigilance. As the healthcare paradigm shifts, I, along with my generation of physicians, hope to adapt to change and continue to provide quality care.

It’s a dream that makes it easier for me to get out of bed on time!
The education of Lt. Gov. Ralph Northam, MD

By Chip Jones

As RAM President Peter Zedler looks on, Lt. Governor Ralph Northam makes a point to Academy members during his Sept. keynote address.

“Your involvement in policy-making as providers is very, very important.”

As he described his own journey into politics? Speaking at the September General Membership meeting, Ralph Northam — a full-time pediatric neurologist in Norfolk and Virginia’s Lieutenant Governor — smiled at the packed house and gave a rueful answer to this rhetorical question: “If there’s a psychiatrist in the room, please meet me on the couch.”

Northam — reportedly the Democratic Party’s front-runner for governor in 2016 — gave Academy members an inside look at his humble (yet costly) jump into elective politics. His public service has direct links to his experiences as a physician and the owner of a large private practice: reimbursement hassles with stingy insurance companies; government paperwork; the soaring cost of medical school education; and, at the end of the day, a feeling of exhaustion and frustration.

Around 2005, Northam began discussing his frustrations over the practice of medicine with the department chairman of pediatrics at Children’s Hospital of the King’s Daughters in Norfolk.

“Why don’t you do something about it?” his colleague said.

At the time, though, Northam said, “I was totally naive politically. I’d never taken sides. I voted for the best person to do the job.”

So this political novice sought the counsel of a handful of legislators about the true financial cost of running for elected office. His advisors included Dr. John M. O’Bannon III, the former RAM president who has long served as a Republican delegate from Henrico County. O’Bannon, along with several other area legislators, were at last month’s Academy meeting at the University of Richmond.

After conferring with General Assembly veterans, Northam continued, he was told to expect to spend about $250,000 to mount his first campaign. No problem, he thought, since “I’ve got all these rich doctors” to call on.

He was elected to the state Senate, but the final bill topped seven figures. “By the end of that race it cost me $1.2 million,” he said.

Northam is a VMI grad who received his MD from Eastern Virginia Medical School. He spent eight years on active duty in the Army, where he was promoted to the rank of major. He now serves as an Assistant Professor of Neurology at EVMS as well as Medical Director for the Edmarc Hospice for Children in Portsmouth.

While serving as Lieutenant Governor makes him the second-highest ranking state executive and gives him a tie-breaking vote in the state Senate, Northam did note that the position is part-time only, with a modest annual salary of $1.2 million, “at least for now.”

Speaking in his trademark low-key manner, Northam said physician involvement remains critical in helping lawmakers sort through the annual avalanche of new legislation. With about 3,000 bills a year introduced in the General Assembly, he said, “It’s sort of like drinking from a fire hose.”

Northam went on to serve in the state Senate from 2008-2013 before his election as lieutenant governor on the Democratic ticket with Gov. Terry McAuliffe and Attorney General Mark Herring. (Under Virginia law, governors can’t run for a second term, and Herring has said he plans to run for a second term as attorney general, putting Northam in the driver’s seat for winning the 2016 gubernatorial Democratic nomination — at least for now.)

In his remarks to RAM, Northam said he’s embraced anti-smoking legislation and measures to protect children against the health hazards of second-hand smoke. Northam’s wife is a school teacher, and Northam said some of the best ideas he’s heard came from the mouths of babes.

One little boy told him, “Every day my mother lights up a cigarette. I asked her, ‘Please don’t smoke in the car.’” This prompted Northam to seek a prohibition on smoking in cars with kids in them, since “smoking for one hour with the windows up is the equivalent of smoking 10 cigarettes” for the child.

The bill failed, but Northam added, “When we write bills, sometimes it’s about education.”

Chip Jones is RAM’s communications and marketing director.

“Best of luck!” Northam called out to Dr. Dunnavant. “I look forward to having another senator helping out.”

With about 3,000 bills a year introduced in the General Assembly, he said, “It’s sort of like drinking from a fire hose.”

Northam went on to serve in the state Senate from 2008-2013 before his election as lieutenant governor on the Democratic ticket with Gov. Terry McAuliffe and Attorney General Mark Herring. (Under Virginia law, governors can’t run for a second term, and Herring has said he plans to run for a second term as attorney general, putting Northam in the driver’s seat for winning the 2016 gubernatorial Democratic nomination — at least for now.)

In his remarks to RAM, Northam said he’s embraced anti-smoking legislation and measures to protect children against the health hazards of second-hand smoke. Northam’s wife is a school teacher, and Northam said some of the best ideas he’s heard came from the mouths of babes.

One little boy told him, “Every day my mother lights up a cigarette. I asked her, ‘Please don’t smoke in the car.’” This prompted Northam to seek a prohibition on smoking in cars with kids in them, since “smoking for one hour with the windows up is the equivalent of smoking 10 cigarettes” for the child.

The bill failed, but Northam added, “When we write bills, sometimes it’s about education.”

Chip Jones is RAM’s communications and marketing director.
Should you have questions about any of our upcoming meetings, please call the Academy at (804) 643-6631.

Do you have a colleague interested in becoming a RAM member? Bring them along to the next RAM event!

**SAVE THE DATE**
For the RAM Alliance Foundation’s 3rd Annual Physicians Got Fashion Show!

**Saturday April 16, 2016**
7–10 p.m.
Tuckahoe Woman’s Club

- Heavy hors d’oeuvres
- Cocktail Reception
- Fashion Show
- Live Auction

Join us for a fun evening to benefit community health initiatives!
On June 6, 2014, the 70th anniversary of D-Day, I had a different kind of phone call with my parents. Instead of my regular check-in — “Hi Dad, how are you and Mom doing?” — I asked, “Dad, where were you on D-Day?”

Like many World War II veterans, for years my father tended not to talk about his wartime experiences. But on this historic anniversary, Dad opened up.

On his third mission, a daytime bombing raid over Berlin, his plane was hit. The centrifugal force of the spiraling plane plastered four of his fellow crew members against the walls of the fuselage. But against all odds and g-forces, he managed to crawl along the floor to the hatch, pull the release and, after the door flew open, shoot out into a sky popping with antiaircraft fire.

Amid the confusion, Dad saw an empty parachute drift upward. This belonged to his B-17’s pilot, who had failed to secure the leg straps of his parachute — and now he was tumbling helplessly to the earth. Things weren’t going much better for Dad, though, because when he pulled his parachute handle at an altitude of 12,000 feet, nothing happened.

As the older of two sons, and with a recently widowed mother, he was briefly gripped by this thought: “What will my mother do if I die?” But he quickly regained his composure, clawed furiously at his chest, and opened the parachute. His troubles had only just begun, though.

Dad arrived in England in April 1944. Unbeknownst to him, he would participate in the 1,000-plane bombing raids designed to soften up Germany before the planned land invasion of “Fortress Europe.” On his third mission, a daytime bombing raid over Berlin, his plane was hit.

The centrifugal force of the spiraling plane plastered four of his fellow crew members against the walls of the fuselage. But against all odds and g-forces, he managed to crawl along the floor to the hatch, pull the release and, after the door flew open, shoot out into a sky popping with antiaircraft fire.

Amid the confusion, Dad saw an empty parachute drift upward. This belonged to his B-17’s pilot, who had failed to secure the leg straps of his parachute — and now he was tumbling helplessly to the earth. Things weren’t going much better for Dad, though, because when he pulled his parachute handle at an altitude of 12,000 feet, nothing happened.

As the older of two sons, and with a recently widowed mother, he was briefly gripped by this thought: “What will my mother do if I die?” But he quickly regained his composure, clawed furiously at his chest, and opened the parachute. His troubles had only just begun, though.

As he floated down toward enemy terrain, German civilians began taking potshots at him from below. When he landed, Dad was actually

“I wanted to forget the war, get married, and get on with my life.”

“I was in Hermann Gering Hospital, Berlin, recovering from the injuries I suffered landing after parachuting out from my B-17,” he explained. “I remember nurses rushing in, shouting ‘Invasion! Invasion! Americans in France!’ I couldn’t believe it.”

I had seen his Purple Heart and known since childhood that my father was a German POW. But over the years, I began to realize how little I really knew about his time in captivity. Even before last June, Dad had started sharing more about this chapter in his young life. He’d been inspired by an ad he’d glimpsed in a flying magazine for a “398th Reunion” — his bomber squadron in the 8th Air Force. Dad decided to attend the reunion and, among his fellow Army Air Corps comrades, he reconnected with the navigator of his plane, the only other survivor of their 10-member crew.

A bit of background is in order: Dad graduated from high school in Detroit in 1942. As a senior with passing grades, he was exempted from final exams if he volunteered to work in the defense industry. So he made the two-and-a-half-hour round trip by streetcar to the Ford River Rouge Plant, the largest integrated factory in the world. It had been converted to serve the defense industry as part of the Herculean war effort mounted by the United States.

But when he turned 18, he was called to serve and volunteered for the Army Air Corps, training as a radio operator.

Dad arrived in England in April 1944. Unbeknownst to him, he would participate in the 1,000-plane bombing raids designed to soften up Germany before the planned land invasion of “Fortress Europe.” On his third mission, a daytime bombing raid over Berlin, his plane was hit.

The centrifugal force of the spiraling plane plastered four of his fellow crew members against the walls of the fuselage. But against all odds and g-forces, he managed to crawl along the floor to the hatch, pull the release and, after the door flew open, shoot out into a sky popping with antiaircraft fire.

Amid the confusion, Dad saw an empty parachute drift upward. This belonged to his B-17’s pilot, who had failed to secure the leg straps of his parachute — and now he was tumbling helplessly to the earth. Things weren’t going much better for Dad, though, because when he pulled his parachute handle at an altitude of 12,000 feet, nothing happened.

As the older of two sons, and with a recently widowed mother, he was briefly gripped by this thought: “What will my mother do if I die?” But he quickly regained his composure, clawed furiously at his chest, and opened the parachute. His troubles had only just begun, though.

As he floated down toward enemy terrain, German civilians began taking potshots at him from below. When he landed, Dad was actually
appreciative that German soldiers got to him before the civilians did. The civilians, frenzied by the destruction being rained on them by American bombers, would have killed him.

On impact, Dad suffered a back injury and was in deep pain when the Germans loaded him into a truck alongside the bodies of his dead crew mates.

My father has always made it abundantly clear that he received excellent medical care in the Berlin hospital before recovering sufficiently to be loaded on a boxcar and sent to Stalag Luft IV (located in what today is Poland). As the Russians advanced from the east, he was one of a hundred men packed into an “8x40” boxcar (eight horses or 40 men). The men were sent back to Germany to a camp in Nuernberg (best known after the war as the site of the Nuremberg Trials of Nazi war criminals). He didn’t stay for long, though, and soon had to make a 15-day-long forced march to Stalag VII-A, Germany’s largest POW camp outside the town of Moosburg in southern Bavaria.

On April, 29, 1945, two weeks before my father’s 21st birthday, the camp was liberated by U.S. forces under the command of Army Gen. George C. Patton. Dad was amazed to see the disappearing act of his captors. The Germans overseeing the Stalag were gone in less than an hour. Before he had a chance to collect what little gear he had, Russian soldiers were barging into the camp, stealing everything from the American POWs’ tent.

Four years ago, I had the privilege of meeting Dad and other WWII veterans in Washington D.C., at the WWII Memorial as part of an Honor Flight tribute. It was a gorgeous day, and tourists were flocking to the monument. One stopped to ask, “What’s going on here?”

When Dad finished telling his story, the man eagerly asked, “So what momentoes did you save? What did you keep from the war?”

Dad eyed him incredulously. “I didn’t save anything,” he replied. “I wanted to forget the war, get married and get on with my life.”

And he did. It.

Postscript: George Graham attended the Illinois College of Optometry on the GI Bill and retired at 79 as the CEO of OptimEyes and the GI Bill and retired at 79 as the CEO of OptimEyes. At 91, he can recite, without hesitation, his service number.

Dr. deBlois is Chief Medical Officer of Virginia Care Partners. She can be reached at Georgean.DeBlois@VirginiaCarePartners.com.
RAM leads victorious charge for “pre-auth” reform

BY CHIP JONES

Looking back on how RAM joined forces with the Medical Society of Virginia to win reform of insurer’s prescription pre-authorization rules, Academy veteran Dr. Clifford L. Deal III compares it to the long, drawn-out island-hopping campaigns of American forces in World War II. Just as America needed to win those key battles at Tarawa, Saipan (HB 1942) and Senate (SB 1262) took effect July 1.

But such success doesn’t come easy, or quickly. It was more than two years in the making and took committed work by RAM activists like Deal, Dr. Richard Szucs and Dr. John Butterworth as well as the Academy’s Legislative Committee co-chairs, Drs. Mark Monahan and Ritsu Kuno. Working with the legisla-

sites; allow for electronic requests; respond to prescription requests within 48 hours; make special provisions for chronic disease management drug benefits and mental health drug benefits; give physicians the ability to override a prior authorization denial when a patient is already stabilized on a certain medication; eliminate the requirement to get prior approval for generic drugs; and make each pre-authorization last for at least one year.

The need for reform followed a steady erosion of control of physician autonomy that dates back more than 25 years, Deal said, adding, “If insurance companies had their way, and Iwo Jima, “We needed a victory for physicians” in the 2015 General Assembly.

Deal, a member of the Academy’s Legislative Committee, was referring to two bills that sailed through the last session of the General Assembly and were then signed into law by Gov. Terry McAuliffe. The identical bills from the House of Delegates (HB 1942) and Senate (SB 1262) took effect July 1.

But such success doesn’t come easy, or quickly. It was more than two years in the making and took committed work by RAM activists like Deal, Dr. Richard Szucs and Dr. John Butterworth as well as the Academy’s Legislative Committee co-chairs, Drs. Mark Monahan and Ritsu Kuno. Working with the legisla-

sites; allow for electronic requests; respond to prescription requests within 48 hours; make special provisions for chronic disease management drug benefits and mental health drug benefits; give physicians the ability to override a prior authorization denial when a patient is already stabilized on a certain medication; eliminate the requirement to get prior approval for generic drugs; and make each pre-authorization last for at least one year.

The need for reform followed a steady erosion of control of physician autonomy that dates back more than 25 years, Deal said, adding, “If insurance companies had their way,
they would require pre-authorization for death.”

Matt Mansell, who served then as MSV’s director of government affairs, agrees with Deal that passionate advocacy by RAM members helped drive the momentum for change. The first discussion of a “pre-auth” law came at the annual legislative summit in 2013, when various proposals were suggested by a number of groups, including RAM and the Virginia Academy of Family Physicians.

“Every person there spoke strongly in support,” recalled Mansell, who has since left MSV.

But like any military operation, this one involved a savvy mix of logistics, strategy, and execution. MSV’s legislative team knew they’d be sitting ducks in the General Assembly if they didn’t enter the battle well-armed with data to convince skeptical legislators.

“We needed to have data on our side to convince them,” Mansell recalled. RAM followed through at this stage of the operations as well and — among many other moves — called together a group of area practice managers to help gather the much-needed intelligence to help make the case.

“RAM was on the vanguard of working to get information,” explained Mansell.

MSV conducted a thorough statewide survey that identified a minefield of obstacles created by insurers that required prior approvals for prescription drugs, imaging, some surgical procedures and lab tests.

“We decided to focus on medications first,” Mansell said, because it was a common problem that cut across practice lines.

MSV heard from members who were frustrated by prescription drug procedures that slowed access to care, limited time spent with patients, and created costly staffing requirements to deal with insurers’ red tape.

Ironically, the vast majority of “pre-auths” were being approved, but they still caused problems for physicians and patients alike when insurers and health plans used them as “delay tactics,” Mansell noted.

Following the intelligence gathering, MSV convened a “pre-auth working group” to plot the overall strategy that would be used to present the case to lawmakers.

But, Mansell recalled, “Legislators told us before you bring anything forward, work it out with the health plans.” This was easier said than done, though, because “there was no common ground, and insurers were more interested in controlling costs than in ceding any authority.”

Meanwhile, he said, “The

“Victorious,” continued on page 16

---

**relayfoods**

The healthy online grocery store.

Your entire break room, always on call.

Stock a healthy office. Order online for next-day delivery.

Get $20 off your first order of $50 or more!

**USE THE CODE:** RAM20

**WHEN YOU CHECK-OUT AT relayfoods.com**
how important it is for physicians to involve themselves in advocacy," said Butterworth. “We won an important victory on an issue that concerns nearly every physician and nearly every patient.” And for members who might wonder whether they have time to get involved, he noted, “Remember this victory when it comes time for a White Coat Day or a RAM-sponsored legislative event.”

Chip Jones is RAM’s communications and marketing director.

We’re In Your Neighborhood

The health care services and programs of VCU Medical Center are now closer to your patients and you at the following convenient outpatient locations:

VCU MCV Physicians at Mayland Court
3470 Mayland Court
Henrico, Virginia 23233
(804) 527-4540

VCU MCV Physicians at Temple Avenue
Puddledock Medical Center
2035 Waterside Road, Suite 100
Prince George, Virginia 23875
(804) 957-6287

VCU MCV Physicians in Williamsburg
1162 Professional Drive
Williamsburg, Virginia 23185
(757) 220-1246

Commonwealth Neuro Specialists
501 Lombardy Street
South Hill, Virginia 23970
(434) 447-9033

Internal Medicine and Pediatric Associates
Chesterfield Meadows Shopping Center
6433 Centralia Road
Chesterfield, Virginia 23832
(804) 425-3627

South Hill Internal Medicine and Critical Care
412 Durant Street
South Hill, Virginia 23970
(434) 447-2898

What does the Academy do well? Please email Jim Beckner at jbeckner@ramdocs.org and let him know.
WE ARE UNMATCHED IN REWARDING OUR MEMBERS FOR PRACTICING GOOD MEDICINE

As a company founded by doctors for doctors, we believe that doctors deserve more than a little gratitude for an outstanding career. That’s why we created the Tribute® Plan—to reward our members for their loyalty and commitment to superior patient care with a significant financial award at retirement. How significant? The highest distribution to date is $138,599. This is just one example of our unwavering dedication to rewarding doctors.

Join your colleagues—become a member of The Doctors Company.

CALL 888.896.1868 OR VISIT WWW.THEDOCTORS.COM

Tribute Plan projections are not a forecast of future events or a guarantee of future balance amounts. For additional details, see www.thedoctors.com/tribute.
America loves a winner but reserves its lukewarm nods for those who finish second—otherwise known as a “runner-up.” Consider the 2015 Super Bowl: Even though the Seattle Seahawks played a brilliant game, an errant pass by former Collegiate star Russell Wilson led to a big “L” for the Seahawks and a bigger “W” for Tom Brady and the winning New England Patriots.

All year long, the Seahawks’ coach who called the decisive play, Pete Carroll, has been trying to live it down.

Over my six years treating colon cancer, I’ve noticed how this “winner take all” mentality has a way of trickling down to how the public—and even healthcare providers—perceives this dangerous disease, which ranks No. 2 for cancer death among men and women.

According to the most recent statistics from the U.S. Centers for Disease Control and Prevention, 51,516 people in the U.S. died from colorectal cancer in 2012, with the number of men (26,866) slightly outpacing that of women (24,650). That makes it the second leading cause of cancers that afflict both men and women (lung cancer is the leading cause, while, for women, breast cancer is the most fatal cancer).

Despite causing so much loss and anguish, this “runner-up” cancer has over the years failed to be taken as seriously as other forms of cancer—especially given the fact that early detection can lead to the successful removal of cancerous polyps. In many ways, I’ve found, colon cancer is the Rodney Dangerfield of the cancer world, still not getting the respect it deserves.

Colon cancer, despite its dangers, is a topic few are willing to discuss. It’s gross and taboo. While screening colonoscopies are recommended by primary care physicians, many patients often delay or refuse the test for a variety of reasons: inconvenience of taking a day off of work for testing, fear of the dreaded “gallon of GoLYTELY,” or social anxiety about a rectal exam. Eventually, with enough prodding by their doctors, friends and family as well as patients’ overwhelming fear of having colon cancer, we have been successful in getting 66 percent of appropriately-aged (over 50 years old) Richmonders screened.

In terms of a screening program, that’s quite a success. But when you’re talking about a disease that is virtually symptomless until the later stages, we need to do a much better job in order to knock colon cancer from its runner-up position.

Nationwide, there are several charities whose mission is improving research and awareness of this epidemic. But until 2011, Richmond had
no organizations or events dedicated solely to colon cancer. The silence on this topic was breathtaking. For a city that raises the banner of myriad worthy causes, to remain silent on the second-leading cause of cancer-related death seemed like a major oversight.

In 2011, Mindy Conklin and I began planning a race to benefit colon cancer research and awareness. We each approached Richmond Road Runners individually and were thus introduced. Mindy lost her husband, Rich, at the age of 43, to colon cancer. She had run races out of state to raise awareness of colon cancer and to raise funds for research nationally. But when I met Mindy, we both agreed that our events should benefit our localities. We would be asking our friends and families to support us in the hopes that we could enlighten and empower our neighbors to live healthier lives. We needed to focus our attention locally first.

So we did. Since 2011, under the 501(c)(3) Hitting Cancer Below the Belt (HCB2), we have organized a yearly 5K walk/run (Boxer Brief 5K), several golf tournaments (Teeing Off on Cancer) and a bowling tournament (Strike Out Cancer). With generous support from MEDARVA and many other medical groups and individuals, we have raised more than $100,000 for colon cancer awareness and research programs supporting the area. HCB2, with the help of the Richmond Academy of Medicine’s Access Now, its affiliated free clinics and participating gastroenterologists and colon and rectal surgeons, has helped organize two free colonoscopy screening days over the last year for patients with limited or no access to specialty care. Approximately 40 percent of patients screened were found to have polyps.

Early detection is key to the prevention of colon cancer. Normal colonic mucosa mutates over time to create abnormal growths or polyps. Left unchecked, these polyps degenerate and become colon cancers. Taking polyps out before they become colon cancer is the key to prevention. Even if a polyp has mutated to become a cancer, early detection is key to survival.

In either case, a colonoscopy can be life saving. Preventable, beatable, treatable. This is our mantra when it comes to colon cancer. Yet there are 150,000 new cases of colon and rectal cancer and 50,000 deaths each year attributable to colon and rectal cancer. With Richmond’s support of HCB2, we can start talking about our bowel movements and save some lives.

Visit Hitting Cancer Below the Belt at www.hcb2.org.

“Virginia Cancer Institute gave me the Power to Fight.”

Meet Kevin. He’s an artist, a barbershop owner, a husband — and thanks to Virginia Cancer Institute, he’s a cancer survivor. When Kevin was a patient at VCI, a team of physicians and staff worked together to help him take on cancer. These doctors included Richmond Magazine’s Top Docs for oncology. Kevin’s Power to Fight story will move you, and his strength will inspire you.

See Kevin’s story firsthand at vacancer.com
Did you know that the Richmond Academy of Medicine Services Corporation (RAMSC) manages medical societies? The service and professional expertise provided by RAMSC are tailored to each society’s individual needs and help relieve societies and their leaders of the administrative details necessary for an efficient operation at a more economical cost.

Here are some compelling reasons for outsourcing the work of your specialty society!

1. To contain cost. Full-time employees are expensive. They come with associated costs and, when they do the job right, you want to reward them with raises. Sometimes problems arise. Board members are asked to be HR professionals. Outsourcing contains personnel cost and removes HR management from your plate.

2. To contain cost even more. Headquarters require computers, telephones, faxes, Internet access, copy machines, work areas, boardrooms, lights, carpets, water, heat and AC. Periodically, these things need replacement or upgrading. By outsourcing, you get out of the purchasing/leasing role and give that responsibility to us.

3. To improve resource allocation. Volunteer board members are freed from the burden of personnel hiring, payroll, government requirements, benefits, capital acquisitions, finding/leasing space and other infrastructure-related responsibilities.

4. To broaden your resource base. We give you greater access to service-focused professionals who are experienced in all phases of association activity. Having access to — and eventual adoption of a best practice, idea, tool, methodology or lesson learned — can save time and cost, reduce risk and improve productivity and performance.

5. To grow. To grow and to build sustained competitiveness. We continuously work to hone our knowledge, resources and best practices so your organization will excel at three fundamentals of growth: creating and maintaining a compelling value proposition for members; being “easy to do business with;” and communicating and marketing in effective, consistent and frequent ways.

6. To improve financial controls and practices. We have internal controls and practices that are time-tested to ensure the highest levels of integrity and reliability.

What does the Academy do well? What could the Academy do better? Please email Jim Beckner at jbeckner@ramdocs.org
The internal control system is augmented by policies and guidelines, careful selection and training of qualified personnel and detailed review procedures.

7. To have access to experts. Such access includes law firms and certified public accounting firms with strong association practices as well as investment and insurance companies that provide association-tailored services.

We currently manage eight organizations: the Virginia Chapter of the American College of Surgeons; the Virginia Chapter of the American Academy of Pediatrics; the Virginia Society of Otolaryngology–Head and Neck Surgery Inc.; the Virginia Surgical Society; the Virginia Chapter of the American College of Radiology; the Virginia Radiology Political Action Committee; Virginia Academy of Sleep Medicine; and the Richmond Medical Group Managers Association.

Some of the many positive reviews that we received from the societies we manage include:

- “Excellent group of people to work with.”
- “Excellent, professional, timely, and facilitating.”
- “Very pleased with our transition and our current management.”
- “Best Executive Director that we have ever had.”
- “Wonderful service delivered at a very fair price.”
- “Excellent performance; timely and responsive to our needs.”
- “Absolute pleasure to work with the Staff at RAMSC.”

Can RAMSC help YOUR Society? Call Jane Chappell at (804) 622-8135 to find out more! 

Jane Chappell is Executive Director of the Virginia Chapter of the American Academy of Pediatrics & The Virginia Pediatric Society and be reached at (804) 622-8135 or jchappell@ramdocs.org. Susan McConnell is Executive Director of the Virginia Chapter, American College of Surgeons; the Virginia Surgical Society; the Virginia Society of Otolaryngology–Head and Neck Surgery Inc.; and the Virginia Academy of Sleep Medicine and can be reached at (804)622-8139 or smcconnell@ramdocs.org.

Lara Knowles is Chapter Coordinator of the Virginia Chapter of the American College of Radiology and the Virginia Radiology Political Action Committee and can be reached at (804) 622-8137 or lknowles@ramdocs.org.

Kate Gabriel assists the Richmond Medical Group Managers Association and can be reached at (804) 622-8133 or kgabriel@ramdocs.org.

MEMBERSHIP IDEAS? We want to hear them!

Send your thoughts or suggestions to Kate Gabriel (kgabriel@ramdocs.org) or call her at (804) 622-8133.
Showing you care

BY LUCIEN W. ROBERTS, III

Lucien W. Roberts, III, MHA, FACMPE
is Administrator at Gastrointestinal Specialists Inc. He can be reached at lroberts@gastrova.com.

S

lide on over: The Institute of Medicine’s (IOM) tripod (quality, access and cost) has company. The Affordable Care Act (ACA) has introduced a different three-legged stool — quality, patient satisfaction and payment — upon which physicians will be asked to balance. Quality is a key element with both the IOM and ACA tripods, but there’s a key difference with the ACA’s: Your patients are now the arbiters of quality. Quality more or less equals patient satisfaction … that’s the premise, like it or not. This article discusses the ACA’s tripod stool and offers recommendations for achieving balance.

The government’s working hypothesis breaks down as follows:
1) Patients who like their doctors are more likely to be compliant patients.
2) Compliant patients are healthier patients.
3) Healthier patients are less expensive.
4) So, physicians with satisfied patients should be paid more than physicians with dissatisfied patients.

Large physician practices and hospitals already have their Medicare payments linked in part to patient satisfaction. The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey is Medicare’s standardized tool to measure patients’ perception of care provided by physicians in an office setting.

Over the next few years it will be an integral portion of physician payment, possibly dwarfing the penalties under Meaningful Use.

What’s being measured?

- CG CAHPS measures the patient experience, an expansive proxy for quality that takes into account the following:
  • Timely appointments
  • Timely care (refills, callbacks, etc.)
  • Your communication skills
  • What your patient thinks about you
  • What your patient thinks about your staff
  • Whether your office runs on schedule

I have been in enough medical practices — both as a patient and as an administrator — to know there’s a method to this madness. It’s less about the care and more about the caring. So here are my suggestions for showing the government that you do care:

Begin on time to stay on time

The CG CAHPS survey places emphasis on whether patients are seen within 15 minutes of their appointment times; it’s even underlined for emphasis. Physicians who start on time are more likely to run on time, so have your feet set before you start running. I don’t know that doctors who run on time are the best doctors but clearly the government thinks this to be the case.

And when you’re late …

Running late is not fatal to patient satisfaction, provided: 1) your staff does a good (and empathetic) job of keeping your patients aware of delays; and 2) you apologize to your patients. It’s amazing how a caring
staff and a sincere apology can defuse even the angriest of patients.

‘Hire happy’

I can train anyone to do anything in our office, but I can’t train happy. Some folks wake up happy and optimistic, while others wake up looking for a reason to justify their bad mood. Patient satisfaction (aka your “quality”) will improve when you “hire happy.” I have found another cost-saving benefit to hiring happy: employee turnover shrinks.

It’s a team effort

Your staff has an important bearing on the patient experience ... help them connect the dots between what they do and your patients. One of my favorite parts of the job is helping my staff appreciate that all of us — even the nonclinical folks like me — can improve quality simply by being friendly and helpful to our patients. Making a patient’s day is a wonderful thing.

Drive patient expectations

It’s helpful to answer “frequently answered questions” about your practice so patients will know what to do for refills, after-hours needs, appointment scheduling and other FAQs. By making these answers readily available on your website, your portal and in your print materials, you’ll better align patient expectations with patient experiences. And your scores will start climbing.

Here’s an example: antibiotics

Some patients gauge quality by whether they get the antibiotic they think they need. Temper this expectation by including cautionary education on antibiotic overuse in your patient education materials, especially if you are in primary care.

Listen with your ears AND your eyes

Nothing says “distracted” like having your physician focus on a computer screen rather than on you. This is particularly true in the first couple of minutes of each visit; new patients in particular need your providers to listen with their eyes. One virtue of using scribes is that you can listen with your eyes a whole lot more.

The value of follow-up

One area where most of us can improve is letting our patients know what to expect after their visit (test results, follow-up visits and other routine matters). Actually, I receive more complaints about the back end...

Care,” continued on page 24

“After talking to many executive directors from all areas of Virginia, once again I realized how blessed the Central Virginia area is to have the great services of Access Now! Our worst scenario is having to wait an extra week for services. What a time, effort, and money-saver we have with Access Now. Thank you to all the many specialty doctors, staff and facilities and health systems that make up the Access now program!”

– Connie Moslow, Executive Director, Free Clinic of Powhatan
of the patient’s experience than about the front end. So the after-care caring we provide is what transforms patients into fans.

**Lead by example**

It may seem obvious, but it’s still worth reiterating: Our employees follow our examples. If the practice’s leaders practice what they preach — running on schedule, being kind to patients as well as to patients’ families and to each other — our teams will do the same.

Patient satisfaction always has been a barometer of quality, and it remains so today. Viewed in this light, the government’s new “incentive” plan offers you an opportunity to demonstrate the daily caring that’s always been at the heart of the medical profession.