It must begin with us

BY PETER A. ZEDLER, MD

It is a deep honor to stand before you as the 117th president of the Richmond Academy of Medicine. For nearly two centuries the Academy has been an integral part of the medical framework of Virginia’s capital city. You don’t need me to tell you that this association has survived despite a Civil War, a Great Depression, two world wars, Korea, the Vietnam War, the advent of Medicaid and Medicare, the rise of managed care, HMOs, PPOs, and the advent of hospitalists and incrementalists. But there is much more than tradition and history that sustains us—at our core, this Academy has existed to uphold a noble profession and to create a community in which that profession can flourish. For those of us in medicine, change has always been part of our DNA. We are constantly looking for better ways to care for our patients. Consider all of the new medications that have been developed just in your career. We now keep our notes on computers instead of paper and ink. We have robots to help us operate…In our lifetimes, there have been staggering changes in the delivery of medicine, from in vitro fertilization to vaccinations to prevent cervical cancers. We have also seen changes in the way healthcare is organized and paid for. But perhaps the biggest change, the proverbial elephant in the room…is now upon us. The Affordable Care Act…or Obamacare.

The official launch of the Affordable Care Act, this past October 1st, is a date that will be remembered by all of us in this room. For some, it is a date that will live in infamy, while for others it marks a date of hope and possibility. But however we view the president’s signature legislative initiative, we can all agree that it is already having profound effects on patients.

“Begin,” continued on page 2

Changing all those changes

BY ISAAC L. WORNOM, MD FACS

The great Buddy Holly got it right when he sang, “I should have reconsidered all those things I said I’d do/So now I’m changing all those changes/That I made when I left you.” Those of us who actually heard Holly sing when we were kids can attest to the constancy of change, and how perspective gives us all a bit more wisdom—even the bittersweet variety that Holly is expressing! Having practiced medicine in the River City for nearly two centuries, the Academy has existed to uphold a noble profession and to create a community in which that profession can flourish. For those of us in medicine, change has always been part of our DNA. We are constantly looking for better ways to care for our patients. Consider all of the new medications that have been developed just in your career. We now keep our notes on computers instead of paper and ink. We have robots to help us operate…In our lifetimes, there have been staggering changes in the delivery of medicine, from in vitro fertilization to vaccinations to prevent cervical cancers. We have also seen changes in the way healthcare is organized and paid for. But perhaps the biggest change, the proverbial elephant in the room…is now upon us. The Affordable Care Act…or Obamacare.

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“Begin,” continued on page 2

Hazel’s heavy lifting

BY CHIP JONES

No one would ever call Dr. William A. Hazel Jr. a lightweight. When he enters a room, he’s broad-shouldered and evokes confidence and power. But those attributes alone don’t account for the success Bill Hazel has enjoyed as Virginia’s Secretary of Health and Human Resources over the past four years. Hazel, who was recently reappointed to a second term by Gov. Terry McAuliffe, casts a unique intellectual gravitas when he begins speaking on the often arcane issues of healthcare policy.

This “recovering” orthopedic surgeon—and a former team doctor for the Washington Redskins—knows how to dissect health policy with the precision of a pro quarterback hitting a long bomb in the end zone.

“Bill Hazel has an incredibly bright intellect that can quickly understand and then explain the most complex aspects of health care delivery and health care reform,” said Dr. Larry Blanchard, a former RAM president who’s known Hazel for years. “He can make the difficult decisions and advocate for sensible positive public policies and do so in a way that garners support from both sides of the aisle politically.”

Which is why when he was reappointed in late December, many Academy veterans saw it as a winning move for physicians and patients alike.

Given the panoply of tough issues ahead—from the Affordable Care Act to Medicaid expansion in Virginia—“Dr. Hazel understands the concerns of Virginia physicians as we grapple with these difficult issues,” said Dr. Peter A. Zedler, RAM president.

From a practice manager’s perspective, Charles “Bert” Wilson, of Dermatology Associates of Virginia, noted Hazel’s “extensive experience in the business of building and successfully running a cutting-edge orthopedic practice.” Hazel, a graduate of the Duke University School of Medicine who completed his orthopaedic residency...
“Begin,” continued from page 1

and physicians alike…

Last year, on the day after the Supreme Court affirmed much of the law, I had the opportunity to hear the former senator from Tennessee, Dr. Bill Frist, declare that we now knew that the Affordable Care Act was the law of the land. There is no going back. The most optimistic in the room predicted that with improved coverage doctors might see more patients. Patients might take advantage of the availability of preventive care and this, in turn, would lead to better health for our patients and reduce cost for all Americans.

But will it work? Obviously, the jury is still out…. But tonight I’m not here to debate the Affordable Care Act. I’m here to look ahead and to celebrate our common heritage of healing. Our challenge is to continue to provide the best care we can for our patients in an equitable and sustainable way for physicians and our community.

Our members are drawn from throughout the region. Some of us come from the VCU/MCV academic community where, with the encouragement of Dr. John Ward and Dr. Wyatt Bealey, we are now blessed to have VCU providing membership dues to the Academy for its faculty members. That generosity means our membership now tops 2,300 members. With HCA Virginia and Bon Secours Richmond providing the same level of membership support, we are honored that all three of our region’s major hospital systems are key supporters of organized medicine, and we pledge to continue to earn their support.

Your Academy of the 21st century is comprised of physicians of all political and practice stripes, but we can all recognize the truth that our focal point has always been the care of our patients. We must be their advocates. While we are diverse, I think we can agree that the voice of organized medicine must be heard as our healthcare system evolves. Indeed, we should be the best and brightest voice in this discussion, because this is our calling, our profession and our patients. As such, it deserves our very best efforts.

So our healthcare system faces many tough questions. What will happen in 2015 when the employer mandate takes effect? Will our patients be able to keep their doctors? What will physician panels look like in these exchanges? Will there be enough physicians to see these newly insured patients? How will our young doctors pay for their education?

Thinking of these and so many more questions, we can see the importance of banding together here, in the state capital, just a stone’s throw from the General Assembly and the governor’s mansion…. I guarantee you that our presence at “White Coat Days” with our allies at the Medical Society of Virginia is more critical than ever. With so much at stake, as one member recently told me, “Not being at the table means you are on the menu!”

As a practicing physician for over 30 years, I know that what we do is hard work and that physicians are busy people. Balancing time between work and your life can be challenging. I know from experience how easy it is to drift away from organized medicine. But I hope you’ll make RAM a priority in your life….

I also hope you’ll attend our social events and general meetings to catch up with friends or make new ones. Do bring a new colleague to consider joining our ranks and expand our perspectives. Taken together, this is our core mission, providing our members a safe haven for constructive discussion and debate, but also providing active advocacy and publicity for your best interests. Being part of organized medicine is being part of the solution. This mission, and this work, is important, and so I’m proud to accept this new leadership role.

$14,000

Per capita cost for every American by 2021 for healthcare, up from nearly $9,000 today.

“Hazel,” continued from page 7

at the Mayo Clinic, is a founding member of Commonwealth Orthopaedics and Rehabilitation in Northern Virginia. He’s also a former president of the Medical Society of Virginia who volunteers at the RAM Mission of Mercy in southwest Virginia.

His reappointment was criticized by some abortion rights activists who blame Hazel for not vigorously opposing legislation that imposed strict building codes on abortion clinics and a bill that, before it was amended, would have required women to get a vaginal ultrasound before an abortion.

But supporters said the anger was misplaced because “the secretary was considered a moderate when McDonald appointed him four years ago, so much so that his selection was a touchy choice for a Republican who was a longtime favorite of the anti-abortion movement,” reported The Washington Post.

“He is a genuine expert on healthcare reform and has been moving Virginia to the forefront of the nation,” State Sen. Janet D. Howell (D-Fairfax) told the Post.

Among his major accomplishments thus far:

- Successfully negotiating a settlement agreement to resolve a complaint brought by the U.S. Department of Justice regarding Virginia’s care and treatment of people with developmental disabilities at state-run training centers. He also led an effort to move these residents out of such centers and into community homes.

- Leading the Virginia Health Reform Initiative, including the creation of the Virginia Center for Health Innovation.

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"Changes," continued from page 1

Front and center in most of our minds is the Affordable Care Act, otherwise known as Obamacare. As this law moves forward to change the way medicine is paid for and practiced in the USA, it’s clear that each one of us will be impacted. I have dutifully read all I need to know in the papers, attended every seminar that RAM has held about the Affordable Care Act, and tried to understand what it will mean for me, my practice, and most importantly, for my patients. Yet, I still don’t know what’s going to happen.

One of the messages that seems to resonate in all that I read and hear is that over the next year or two we are going to evolve from a fee-for-service system—where each encounter is paid for separately—to a more global payment system where large entities such as hospital systems or insurance companies will be paid a single yearly fee to care for each patient. Within these entities, decisions will need to be made on how the money is spent to provide patient care. The point of this change is to drive efficiency and decrease cost while maintaining quality. Whether this will succeed remains to be seen.

What I do know is that doctors must have a seat at the table when the decisions are made about how the money is divided. Among all the stakeholders in these decisions, we are the only ones who have taken an oath to care for the patients. We are also the ones with the knowledge base about patient care to make the tough decisions that will need to be made. The potential for divisive lights is great and doctors must keep patient care as the primary focus in these discussions. Otherwise we will lose credibility. Great changes are also underway in the way new doctors come to be. Medical education is undergoing a revolution driven by the dynamics of group learning and technology. When most of us were in medical school, we spent the first two years in a dark lecture hall for eight hours a day, five days a week listening to talks and looking at overhead projectors and slides. The slides eventually became PowerPoint presentations, but the experience stayed the same. While in our first year at the University of Virginia School of Medicine, my friends and I called ourselves mushrooms because we grew by sitting in the dark and getting fed stuff. Our job for the first two years of school was to memorize facts and details with the faith that they would one day help us be good doctors.

Today’s medical students at VCU and UVA spend their first year sitting around tables with computers doing group projects and collaborating to solve problems. It is through group learning that the concepts and facts are conveyed. It is a sea change in medical education. We hope to explore this topic later in Ramifications.

Finally, I think 2014 is going to bring a lot of discussion about changes to care for patients near the end of their life. For many people, making their wishes known to their family about end-of-life care ahead of time is difficult. If discussions about their wishes occur ahead of an acute illness it can make decisions easier for all involved. Physicians can advocate for frank discussions on these difficult subjects and RAM is making an effort to raise the level of awareness in our community.

I had a daughter marry last year right before Thanksgiving. It was such a happy joyous family event, but it was a big change for our family. In 2014, our Richmond medical family is facing many changes—though not all of them are joyous and happy. As a generally optimistic person, I try to stay upbeat and hopeful about what is coming. That said, I am also a realist. I sense that many of us may be carrying a heavy load of dread and fear about what the next year will bring. I think the key for all of us in our professional lives is to stay patient-focused. We are still the only ones out there who can actually render care. This gives us great power. We must not be afraid to use it for the good of our patients, even as we keep “changing all those changes.”

Dr. Wornom practices at Richmond Plastic Surgeons and is a past president of RAM. He can be reached at Wornom@richmonddplasticsurgeons.com.
The challenges of Meaningful Use Stage 2

BY JOHN D. BOWMAN, MD

The Institute for Healthcare Improvement (IHI) launched the Triple Aim initiative in 2007. Through this effort, IHI hoped to improve health care in the United States by focusing on the following three dimensions:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Over the last few years, medical groups and hospitals have rapidly purchased or upgraded electronic health record (EHR) systems. The vendors have scrambled to provide the appropriate electronic health record certification. In return, Congress has approved financial incentives for EPs and hospitals that achieve the desired Meaningful Use measures.

As of October 2013, the efforts had proven to be largely successful with close to 90 percent of hospitals and 70 percent of EPs attesting to Meaningful Use Stage 1. Eighteen thousand dollars was rewarded for Stage 1 attestation with additional amounts of $26,000 allocated to the remaining stages for a total of up to $44,000. And by early December 2013, CMS reported that $17 billion in incentive compensation had been paid out since the start of the program.

Among clinicians, there seems to be mixed reviews as to whether the costs of software and hardware upgrades, costs for in-office work flow changes and education, and costs of interface construction are adequately offset by these incentives. This is not to suggest ignoring the incentives. Over the next few years, financial penalties kick in rising to 4 percent of a physician’s reimbursement from Medicare for services to patients. These can begin as early as 2015.

The Meaningful Use program still faces significant hurdles in completion as the rules become more difficult to follow. Many of the Stage 2 measures absolutely require that groups develop a portal for information exchange and secure messaging with patients. The EHR vendors face challenges in accounting for and tracking elements to document compliance. Rural areas face challenges because there is often a lack of broadband coverage to sustain the data transfers. And in most areas there is no defined standard of interoperability to allow the required exchanges of clinical summary documents to be imported or exported when there is a transition of care. In Richmond, interoperability remains a problem due to the almost even split of acute care hospitals using Cerner, Epic and Meditech EHRs. There is also concern that the measures and menu items are not well-suited for specialty care and tend to favor primary care needs.

Acutely aware of these concerns, the ONC has reached out. In July, the ONC and representatives from the Standards Committee and the Policy Committee held a hearing in Washington. Tom Pagano, chief information officer of HCA’s Capital Division, testified on behalf of acute care facilities.

Through the American Academy of Orthopaedic Surgeons, I was invited to present the specialist’s case for modifying future Stage 3 measures and reconsidering Stage 2 items. A request was made to create menu item selections that meet the specialist’s needs. Combining the numerous mandates—eprescribe, CQMs, PQRS and MU—into one unified report to one federal agency was suggested.

As a result of that testimony, CMS-HHS requested a visit to OrthoVirginia. In early September, Dr. Helwig, MD, and two team members came to Richmond to see firsthand how the federal measures impact the daily work flow. Dr. Helwig serves as a medical officer in the U.S. Department of Health & Human Services Agency for Healthcare Research and Quality.

Her group was keenly interested in OrthoVirginia’s recent deployment of a patient portal by OBERD that will also allow tracking of outcomes of many of the big-ticket procedures for which Medicare pays, e.g. total joint replacement and spinal surgeries. In the conversation that followed, it became clear that practice-
ners could play a role in modifying the direction of future federal mandates. Dr. Helwig was receptive to the idea that good-outcomes data may eventually be accepted in lieu of the usual Meaningful Use measures.

Two major announcements from CMS and the ONC were released during the first week of December 2013. The first announcement involves reporting to PQRS (Physician Quality Reporting System). In the 1,300-page document that set new rules for “Revisions to Payment Policies Under the Physician Fee Schedule,” the second half of the document waives old PQRS rules for those EPs who can provide acceptable outcome data. And then on Dec. 6, HHS/ONC announced that Meaningful Use Stage 2 has been pushed back to 2015 and 2016 for those EPs who have not already done two years of Stage 1 in 2012 and 2013. After those two years, Stage 3 will begin in 2017.

In summary, despite the one-year reprieve, the burden remains for the medical community to refine its efforts. This year, software vendors must catch up. Interoperability within the Richmond community must be enhanced with ConneCtVirginia through MedVirginia leading the way. Patient engagement will increase with the use of portals but it will be limited at first. Until there is a standard portal document that will share all of the demographic, registration, and basic health history data, how can anyone expect patient buy-in? We have a lot of ground to cover, but the Triple Aim must remain our focus—reduce cost, manage the population health including that of the many newly insured, and improve the patient experience through better interoperability and standard formats.

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ICD-10: The next time bomb?

On Oct. 1, 2014 the anniversary of Healthcare.gov’s ill-fated and embarrassing launch, another potential information technology time bomb looms.

That day, the new ICD-10 coding system replaces ICD-9, which has been used in the U.S. for more than 30 years.

Fresh from the emotional and infrastructural demands of electronic health records, Meaningful Use and other requirements of the Affordable Care Act, practices have emitted a collective groan—but then a grudging resolution to accept ICD-10. After all, failure to do so could result in not getting paid for services rendered.

“I don’t know if physicians will ever embrace it, but they’re going to have to deal with it,” said Tom Gallo, executive director of the Virginia Cancer Institute.

Charles “Bert” Wilson, practice administrator at Dermatology Associates of Virginia, predicts “Oct. 1 will not be fun.”

Though many practices are hoping for another postponement (there have been several), most experts agree that the ICD-10 launch will indeed happen in the fall.

“At the very least, physicians will have to change the way they document a patient’s disease,” said Beth O’Donnell, CEO of Virginia Cancer Institute.

Documenting has always been a part of work, but ICD-10 is about eight times as complicated as its predecessor. And less than half of the current codes will crosswalk.

Though many practices are hoping for another postponement (there have been several), most experts agree that the ICD-10 launch will indeed happen in the fall.

The consequences of not following exactly are still unknown, said Jaci Johnson, president of Practice Integrity and a healthcare consultant with expertise in compliance issues.

“Let’s say you’re a pediatrician and the child comes in with an ear infection. If you don’t note whether it’s the right or left ear, you’ve got an unspecified code. Can the carrier deny that because you didn’t specify which ear, or are they going to pay it anyway? We don’t know yet.”

There are a lot of unknowns in the new system, she said.

For many people, the first question is why change to ICD-10 in the first place.

ICD-10’s myriad codes will help drill down the data, said Johnson.

“It’s a way to better describe out-
ICD-10 is the shorthand for the 10th revision of the International Statistical Classification of Diseases and Related Health Problems. It’s used for billing purposes and also for measuring quality and population health management.

February is Heart Month and HCA Virginia is proud to be the leading provider of cardiovascular care in Central Virginia. Our comprehensive services include minimally invasive procedures such as the non-surgical TAVR valve replacement, and both hybrid convergent ablation and Lariat™ procedures to treat chronic atrial fibrillation. We also engage in research and clinical trials to ensure that we’re on the cutting edge of new technologies and breakthroughs. Insist on the health system with the tools and experience to care for your cardiovascular needs.

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TO LEARN MORE VISIT HCAVIRGINIA.COM
43,900
Number of local health department jobs eliminated in U.S. due to budget cuts.

Wait and see

While you’re waiting to see what happens Oct. 1, here are some tips from ICD-10Watch and Richmond-area experts:

Find value in ICD-10 coding—and then relax
Accept that knowledge is ultimately a good thing. And organizations like the MGMA and AAPC are looking to calm the fears of coders and business staff, said consultant Jaci Johnson. “That’s why they’re doing boot camps with proficiency assessment and finding ways to show that it’s not going to be” such a time-consuming chore.

Train physicians to be teachers
Virginia Eye Institute will incorporate physician-led training into the ways it trains, said VEI’s Lovell Davis, who believes docs will respond better to their peers than to coders or documentation specialists. “I want training done by a physician,” he said. “I think our physicians will respond better.” He’s already distributed copies of the ICD-10 manual to physicians to give them a chance to get used to it. (He’ll also use online training modules and lead some sessions himself when training begins in the summer.)

Customize sessions to fit learning styles
Recognize that people learn in different ways. “I plan to work with each physician individually and base training on their learning styles,” said Kim West of Virginia ENT, who attended an ICD-10 boot camp in the fall. “We’ll make sure their assessments are specific and the notes are clear.”

Minimize effort
“We’re hoping we don’t have to change our infrastructure at all,” said Tom Gallo. To keep ICD-10 training from seeming too daunting, the Virginia Cancer Institute will break training into short but intense sessions. The practice also has developed a system incorporating highly trained “super users” to help shepherd VCI employees through the transition.

Inoculate against disruptions
Physicians need to understand that providing detail may seem tedious, but will save time in the long run by avoiding denials and queries. “Productivity will probably start out slow,” said Davis. “Getting claims out the door may not happen as fast as it does now. He’ll be keeping an eye out for coverage denials and is ready to deal with whatever curves ICD-10 may throw.

“Time bomb,” continued from page 7
IT side. HealthCare.gov certainly did not inspire confidence.
John Halamka, CIO of Beth Israel Deaconess Medical Center in Boston, wrote in his blog, “It will cost the country billions, have limited benefits, and should be considered high risk, given the coordination needed among payer/provider organizations. It is bigger than Y2K for healthcare.”
“The scary part is wondering if the insurance carriers will be ready,” said Kim West, business office manager at Virginia Ear, Nose and Throat. “There are some carriers who have a problem every time there’s a change.”
What remains to be seen, notes Wilson, the practice administrator at Dermatology Associates of Virginia, is whether insurance companies will be ready to handle two sets of coding during the transition and how much of a slowdown the changeover will cause in the system as a whole—and how much that will cost. Pre-authorizations could be tricky, he warns.
What happens if revenue streams are interrupted? Some practices have explored securing lines of credit or other options to ensure income during the transition. No one expects the glitches to be long-term, but many are gearing up for a rough first few weeks (including implementing no-vacation policies for essential staff during that time).
Despite the grumblings from many physicians, coders and business office staff, most are starting the transition to a system that most of the world has used for more than a decade. The only certainty: 2014 will be another year filled with uncertainty. R

Lisa Crutchfield is a Richmond-based freelance writer.
The Richmond Academy of Medicine strives to be the patient’s advocate, the physician’s ally and the community’s partner. Here are some examples of how RAM met its mission last year. They were chosen by Richard A. Szucs, MD, the Academy’s immediate past president.

1. The Patient’s Advocate
Through Access Now, local physicians have contributed $24 million in uncompensated charity care.

2. The Physician’s Ally
Partnerships with three health systems—BSHS, HCA and most recently, VCU—ensure that employed and academic physicians along with those in independent practice are actively involved in the Academy. Keeping the physician community together is our business and our goal.

Academy members enjoyed four general meetings, four Lunch on Tuesdays, three social meetings and one family event.

Members were invited to two meetings with legislators and 52 physicians lobbied during “White Coats on Call” days.

Third District members of RAM contributed nearly $100,000 to the Medical Society of Virginia PAC to support advocacy for physicians and patients and 27 RAM members served as delegates to the MSV Annual Meeting.

Through the Academy’s Service Corporation, nine statewide specialty societies were effectively managed, giving your Academy the opportunity to affect thousands of doctors across Virginia.

3. The Community’s Partner
We renewed our involvement in the Virginia Chamber of Commerce and presented at the Chamber’s subcommittee on health.

A new initiative, Advance Care Planning, was undertaken, including a community forum on this vital issue. We are confident that this will be a tremendous benefit to patients and their families and our community.

Your Academy’s credentialing service (CCVS) initiated provider enrollment services, achieved national recognition by NCQA for its program, and entered new contracts with ACO networks and hospitals.

Dr. J.E.B. Stuart V, an Access Now volunteer at OrthoVirginia, examines a patient’s hand.

Physicians and other healthcare experts gather at last spring’s Advance Care Planning conference.

RAM members at White Coat Day at the General Assembly meet with state Sen. Henry L. Marsh III.

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We welcome the opportunity to speak with you about your investment and retirement planning strategies. Contact us today, and get started on the road to achieving your long-term financial goals.
Thank you, Margaret Lewis

BY GIGI DELBOIS, MD

“Who is she?” I asked my colleague, Dr. George Thomas, as I described the knowledgeable, articulate and stylish woman that I had observed that morning at a Johnston-Willis Hospital committee meeting. It was 1989. As a new member of the Johnston-Willis medical staff, I was just learning the names of key hospital personnel.

“That’s Margaret Lewis, one of our nursing executives,” George replied.

In the 25 years since my introduction to Margaret, she has made her mark as an esteemed healthcare executive, all the while remaining firmly rooted in her clinical ideals and commitment to the Richmond medical community.”

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Dr. deBlois is Chief Medical Officer of Virginia Quality Care Partners. She can be reached at 804-887-2177 or georgean.deblois@virginiaqualitycarepartners.com.

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In the 25 years since my introduction to Margaret, she has made her mark as an esteemed healthcare executive, all the while remaining firmly rooted in her clinical ideals and commitment to the Richmond medical community. She has steadily navigated the turbulent demands of a changing healthcare marketplace, guided by the philosophy that the right decision, always, is to “think of the patient, do what is right for the patient, put the patient first.”

Margaret understood that patients are well-served by a strong local physician organization. She has been a leader who fully supported Richmond Academy of Medicine endeavors ranging from safety-net programs for the medically indigent to the development of a robust healthcare profession credentialing service.

She advocated the development and recognized the potential of the Academy to nurture physician leaders. This includes Dick Hamrick, the HCA Capital Division CMO, Claiborne Irby, president of the board, Henrico Doctors’ Hospital, Edward D. Martirosian, a board member at Henrico Doctors’ and me.

Over the years, as external funding for physician activities diminished, Margaret assured that HCA contributed to Academy educational and social programs that fostered physician collegiality and interaction. Margaret was personally engaged, often attending Academy events and encouraging her administrative teams to do so as well.

I was delighted and honored when Margaret spoke at my inauguration as RAM president four years ago. No matter how densely appointed her calendar, Margaret made time for a visit from Academy members. We enjoyed open, spirited dialogue. When the Academy made a request, she challenged us to provide compelling reasons. Margaret didn’t always
tell us what we wanted to hear, but we knew that she had deliberated carefully; that her word was good. She was unfailingly gracious.

After 37 years with HCA, on a career trajectory that took her from unit nurse to Capital Division President, Margaret retired at the end of 2013. She is unique. How she will be missed! On behalf of the Richmond Academy of Medicine I wish her all the best, and hope that we continue to see her.

Below is the letter from the Academy to Margaret, acknowledging her dedicated service:

December 4, 2013
Dear Margaret:

Thank you for your outstanding service to this region, its many, many patients and the physicians who treat them. In large measure, because of your commitment to quality care and a strong, independent physician community, the Academy has succeeded in implementing programs for the poor, credentialing healthcare professionals and providing educational and social programs that unite physicians.

Over the past thirty-seven years, you have built and sustained relationships of trust and respect among our members—some of whom take great credit for ‘raising you up’ and others whom you have nurtured through your leadership. ‘Your word is a trusted oath. Even when times and circumstances required a stance we did not desire, you dealt with us fairly, openly and with great patience. You are a leader who understands the common rhythm of our medical community.

As a member of the Academy, you are not eligible for ‘Life Membership.’ You are simply not old enough. Yet, we don’t want to lose you or to lose touch with you. Therefore, on behalf of the board of the Academy, it is our privilege and pleasure to extend ‘Honorary Life Membership’ to you. As an Honorary Member, you retain the same rights as any Active Member, yet all future dues are waived.

We hope you will accept this as a token of our appreciation for your many services and of our desire to always count you as one of our own.

Best regards,

Georgean G. deBlois MD
Immediate Past President
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A quartet of issues

Cathy Cawley

New payment models for physician practices
Both government and commercial payers have conducted trials of new models of payment for physician practices that move the focus from volume to value. These payment formulas have the potential to reward doctors for providing improved health outcomes at a lower cost. Yet, the challenge to participate in these programs is that clinicians must think about care across a broader continuum. Changes must be made that will add overhead cost to the practices for such things as upgraded software, EHR system interfaces, care coordination staff, and analytical staff. One obstacle to success is that practices are expected to foot the bill to transform their infrastructures and staff roles, while somehow continuing to be paid under the current volume-based, fee-for-service model.

The practice will receive any bonus income after a retrospective review of outcomes is completed. With tight profit margins in many practices, doctors are being asked to take the risk of a potential future payoff without having any way of quantifying what the real payoff may be.

Collecting from self-pay and high deductible health plan subscribers
Higher numbers of self-pay and HDHP participants may cause a delay and potentially a reduction in the payments received by physician practices. In the past, with traditional insurance plans, practices could expect to be paid within the time specified in the contract between the practice and the payer and not longer than the state law requires. However, with HDHPs the patient will be responsible to pay the full bill until the deductible is met. Therefore the practice will have to research the allowable for each health plan to bill the patient, and also know when the deductible is met. Most often this will result in billing the patient for the service instead of collecting any money at time of service, which puts the practice at risk of waiting until the patient pays. With this system, practices are finding that some patients are unable or unwilling to pay in a reasonable time frame. This increases the burden of collecting more money directly from patients as well as increasing the chance of nonpayment for services rendered.

Medicare reimbursement
Congress passed a budget that will stabilize Medicare payments to physicians and hospitals for a mere two months in 2014. No other industry has had to bear the uncertainty of not knowing whether it will be paid for what may be a very significant percent-age of their business. The continual deferral of fixing the SGR formula—and the specter of a 27.4 percent drop in physician reimbursement—inhibits practices from making important long-term decisions such as the purchase of new equipment, expansion of services and hiring new providers. While Congress has said it intends to solve the SGR problem in 2014, there is no guarantee it will happen and no assurance that other compromises won’t be made in Washington that leave doctors holding the bag.

The ICD-10 transition
In October, physician practices will be expected to change over from the current ICD-9 listing of diagnosis codes to the expanded ICD-10 listing. ICD-10 is meant to provide a much higher level of specificity about the actual diagnosis, but in creating all the subcategories the list has more than 70,000 codes!

This change will be costly on many levels for physician practices. First, new software and possibly upgraded hardware will be needed for the practice management system and the electronic health record system. Extensive training time will be required for most staff including doctors, midlevel providers, and clinical staff and billing staff. The unquantifiable cost will be how it affects provider productivity. Since the main source of income for practices is patient visits, when the visit productivity drops due to providers spending more time on highly detailed coding, company revenue and physician income will also drop.

Editor’s note: We recently asked Catherine L. Cawley, executive director of Commonwealth Primary Care, to offer her thoughts about the biggest issues facing her practice in 2014. She listed the following four issues:
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Prince George, Virginia 23875
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**VCU MCV Physicians in Williamsburg**
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Williamsburg, Virginia 23185
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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

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**RAM events**

<table>
<thead>
<tr>
<th>DATE</th>
<th>MEETING/LOCATION/TIME</th>
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<tbody>
<tr>
<td>March 18, 2014 Tuesday</td>
<td>General Membership Meeting  B. Rick Mayes, Ph.D.-Keynote Speaker  Associate Professor of Political Science  Co-coordinator, Healthcare and Society Program  University of Richmond’s Jepson Alumni Center  5:30 p.m. cocktails, 6:15 p.m. dinner, 7:00 p.m. presentation</td>
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<tr>
<td>April 8, 2014 Tuesday</td>
<td>Lunch on Tuesday  Speaker: Kinloch Nelson, MD  Westwood Club, 6200 West Club Lane  12:00 noon</td>
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<tr>
<td>April 24, 2014 Thursday</td>
<td>RAM Wine Social  Can Can Brasserie  3120 W. Cary Street  5:30 p.m. - 7:30 p.m.</td>
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<tr>
<td>May 13, 2014 Tuesday</td>
<td>General Membership Meeting  Barry Duval, President and CEO  Virginia Chamber of Commerce  Country Club of Virginia  6031 St. Andrews Lane Richmond, VA 23226  5:30 p.m. cocktails, 6:15 p.m. dinner, 7:00 p.m. presentation</td>
</tr>
<tr>
<td>May 22, 2014 Thursday</td>
<td>RAM Family Event  Children’s Museum of Richmond  2326 W. Broad Street  5:00 p.m. - 8:00 p.m.</td>
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**Should you have questions about any of our upcoming meetings, please call the Academy at 804-643-6631.**

Dr. Leon Dixon (far left) with Dr. Zubair Hassan, Loretta Hassan, and Dr. Karsten Konerding at a recent general membership meeting.
This year’s General Assembly session is marked by a number of new faces at the Capitol with the election of Democrats Terry McAuliffe as governor, Dr. Ralph Northam as lieutenant governor, and Mark Herring as attorney general. The statewide attention quickly turned from Election Day to the recount in the attorney general race given its slim margin—but Herring ultimately prevailed in this closest race for state office in modern history. All 100 members of the House of Delegates were up for election in November and at least 14 newcomers came to Richmond last month to serve in the House. While the 40 senators were not up for election, the election of current senators to the statewide offices of lieutenant governor and attorney general created vacancies that were filled by special elections.

While McAuliffe campaigned on a number of issues—including unequivocal support for Medicaid expansion, a desire to significantly reform the Standards of Learning, and additional transportation reforms—he would have to surmount three political hurdles.

The Senate presented the first hurdle with its political balance teetering at a 20-20 tie for Republican versus Democrat going into special elections to fill the senate seats vacated by Northam and Herring. Sen. Northam’s seat was won early last month by Democrat Lynwood Lewis by a mere 9 votes. (The election survived a recount challenge by his Republican opponent, Wayne Coleman, and Lewis’ final margin of victory was a slim 11 votes.)

In the second special election, which was held to fill the vacancy that came with Sen. Herring’s election to Attorney General, fellow Democrat Jennifer Wexton won a three-way special election to represent parts of Loudoun and Fairfax counties in the senate.

After the dust settled, the chamber was evenly split 20-20 between the parties, which effectively flipped it from GOP to Democratic control, with Lt. Gov. Northam holding the all-important tie-breaking vote in all but budgetary matters.

Now the second hurdle: Even if McAuliffe’s agenda survives in the Senate, it then faces the House of Delegates where the Republicans enjoy a supermajority of 68 members with one special election to come. While
Olive branches have been extended from the governor’s office, the House majority is not inclined to cooperate given bitter campaign advertising.

The final hurdle is the budget itself. Both former Gov. McDonnell and Gov. McAuliffe have described Virginia’s budgetary situation with two words: “cautious” and “uncertain.” The projected revenues to be collected are sufficient to fund the current spending obligations but leave little revenue to advance many of the campaign promises from the fall. Gov. McDonnell presented the 2015-2016 budget in mid-December and now it’s up to the General Assembly to consider amendments to what was provided. Then Gov. McAuliffe must decide what he will veto or amend.

The tragedy involving the death of Gus Deeds and the injuries suffered by his father, Sen. Creigh Deeds (D-Bath) has propelled the issue of mental health to the top of the political agenda. Before he left office, McDonnell issued Executive Order No. 68 calling for another $38 million for mental health. Deeds has vowed to make it his priority to achieve mental health improvements and has made good on his promise by submitting a series of bills aimed at closing gaps in Virginia’s fragmented mental health system. This includes a proposal to allow a 24-hour window for holding someone involuntarily under an emergency custody order instead of the maximum of six hours currently allowed under state law. Many argue that the current law doesn’t provide adequate time to evaluate a patient and locate a psychiatric bed. Reform of how psychiatric beds are identified for those patients deemed in need of involuntary admission will be an issue.

An accounting of psychiatric beds that are licensed, staffed and available has been on the drawing board and will now be propelled into action.

Significant attention also is expected on legislation stemming from the “Giftgate” events involving the federal corruption charges brought against McDonnell and his wife. Gov. McAuliffe, as well as members of the House and Senate, has indicated that reforms will be forthcoming this session. This led to a proposal to prohibit elected officials from soliciting gifts and placing a $250 limit on gifts they can receive from lobbyists and individuals with business before the state. It also requires the reporting of gifts to elected officials’ spouses and immediate family members, along with other measures to tighten the state’s ethics, transparency and disclosure laws. This would include the establishment of a State Ethics Commission.

Workers’ compensation legislation will be again taken up by the General Assembly. Workers’ compensation insurers and large employers have proposed limiting increases in the medical cost of workers’ compensation by forcing providers into a Medicare-based fee system. Virginia’s employers enjoy the fourth best premiums in the country, so legislators have encouraged a fresh look at reforms that work but do not cause harm as Medicare-based fee schedules do.

Health care is always a significant discussion point in any General Assembly session. The tulips likely will be in bloom before the General Assembly and governor agree on a budget.

The tulips likely will be in bloom before the General Assembly and governor agree on a budget.
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