

Philadelphia Medicine



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Going from one-on-one healthcare to community involvement a challenge for physicians says Health Commissioner, James Buehler, MD

By David Woods, PhD



“Hi! I’m Jim Buehler,” he says, bounding out of his office to greet a visitor. Back in that equally unpretentious office, James W. Buehler, MD, Philadelphia’s Health Commissioner expounds upon how he took the job and what he plans to do with it.

Dr. Buehler, a pediatrician, says that the public health field has a disproportionate number of physicians in that specialty because of the long term health benefits of implanting healthy habits at an early age. Or, as the Jesuit maxim has it “give me a child by his first seven years and I’ll show you the man.”

His own public health credentials are impeccable. After gaining his MD at the University of California, San Francisco, he went on to become a research professor in the Center for Public Health Preparedness and Research at Emory University. At the Centers for Disease Control and Prevention, he worked on HIV, STD, and TB prevention... and led the initial country assessment teams to Ethiopia and Angola during the startup of CDC’s global AIDS program, and served as a general medical officer in the Lyndon B. Johnson Tropical Medical Center at Pago Pago in American Samoa, where he provided pediatric care services. The recent eruptions of Ebola point out not only the need for preparedness and education... but also the fact that public health is now a global issue.

So how did he wind up overseeing the Philadelphia Department of Public Health’s mission to “protect and promote the health of all Philadelphians and to provide a safety net

for the most vulnerable?” “Well,” he says, with characteristic understatement, “I came to Philadelphia because my wife, a health policy expert, was offered a job here.” As professor of health management and policy at Drexel’s school of Public health he encountered Dr. Donald Swartz, the previous health Commissioner, and became enthusiastic about continuing Dr. Swartz’s leadership and accomplishments, particularly in the areas of children’s health, combating rates of HIV, and working on chronic disorders such as obesity. “But,” he says, “if you’d asked me if I’d be commissioner of public health, I’d have said you’re crazy. “But here I am.”

So what can local physicians do to advance public health initiatives? Commissioner Buehler believes that it’s a question of what he calls ‘improving the handshake’. In other words, taking what doctors find in one-on-one encounters with patients and extrapolating that to the population at large.

Dr. Buehler is also a widely published author of articles, editorials, and reviews. He wrote recently about e-cigarettes, and, as an example of his interest in interdisciplinary projects, an article on funding formulas in public health practice... co-written with an epidemiologist, an economist and a policy analyst.

When not running the staff of 1000 full-time employees and 300 contract ones, mainly in IT services, Dr Buehler is an avid cyclist, looks after the big yard at his home in Mt. Airy and will look to replace the waterskiing that he enjoyed in Atlanta. There’s not much of it in Philly.

Dr. Woods is the editor of Philadelphia Medicine

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Dr. Garibian is a paid speaker for Janssen Pharmaceuticals, Inc.

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Time: Dinner and Program 6:30 PM

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RSVP 215-563-5343, Ext. 113

Seating is limited; please reserve early!

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Maintenance of Certification [MOC]: what is the goal?

by Anthony M. Padula, MD



Physicians are licensed by the state to practice medicine, but they are expected to be board certified in their particular field: surgery, internal medicine, emergency medicine, etc.

Rarely does an issue instill greater passion and considerable angst for physicians than when we bring in Maintenance of Certification (MOC).

Back in 1990, the boards decided that physicians should be recertified every 10 years, which seemed reasonable, but over time, the recertification process has become its own industry.

In December, PCMS hosted a town hall MOC debate that centered on the American Board of Internal Medicine (ABIM). Physicians from Delaware and New Jersey attended our town hall event. The MOC debate included Charles Cutler, MD, PAMED's vice president, who spoke out against the current system, and Richard Baron, MD, president and CEO of the ABIM, who spoke in favor. They each had 15-30 minutes to state their case and each gave a five-minute rebuttal.

A few key points included the ABIM Part III examination pass rate has dropped from over 90% in 2008 to 78% in 2013, appearing to be causing direct harm to many physicians. In the past, the ABIM has selected its own replacements for outgoing board members, furthering the concern that it is insulated from the practice realities of its members and the costs associated with the MOC process, including registration, annual points, exam prep costs, travel costs, exam costs, and lost office time and overhead. Drs. Baron and Cutler's participation is exemplary since two-way professional dialogue is the only way to make it work for all. You can view the MOC debate video at www.pamedsoc.org.

In November, the Pennsylvania Medical Society conducted an online MOC survey of Pennsylvania physicians. It attracted over 850 responses. It found that 88% expressed disapproval of Part IV practice performance assessment that benchmarks patient care data

through practice assessments and patient surveys; 65% expressed their disapproval of the Part III requirements for passing a cognitive exam every five to ten years; and 72% agreed that the Part III exam is punitive and potentially jeopardizes physician credentialing and reimbursement. The MOC survey came after the PAMED House of Delegates this fall directed the Pennsylvania Delegation to the AMA to strengthen AMA policy and emphasize the need for evidence-based practices that are regularly evaluated to ensure physician needs are being met and activities are relevant to clinical practice.

Some of you know that I am Pennsylvania delegate to the AMA, we were successful in changing the MOC principles which will now include: MOC should be based on evidence and designed to identify performance gaps and unmet needs, provide direction and guidance for improvement in physician performance and delivery of care. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, and intent to maintain or change practice. MOC should be used as a tool for continuous improvement. MOC activities and measurement should be relevant to clinical practice. The MOC process should not be cost-prohibitive, or present barriers to patient care. Also at the insistence of the Pennsylvania delegation, those core principles were expanded to include a provision that the AMA work with the American Board of Medical Specialties (ABMS) to eliminate practice performance assessment modules, as currently written, from the requirements of MOC.

In the end, we have to ask ourselves what is the goal of MOC? I look forward to hearing from you. Please let me know your ideas for improvement so that we can act.

Dr. Padula is the President of PCMS.

Host your event at PCMS

Host your next party or conference/ seminar at PCMS headquarters. Ample free parking. Contact Louise Eder on 215-563-5343, Ext. 107 to schedule an appointment.

New child abuse laws pending

Pennsylvania is gearing up for the implementation of significant changes to our Child Protective Services Law (CPSL) which went into effect Dec. 31, 2014.

The law was amended to address concerns with the adequacy of protections for abused children in Pennsylvania. As a result, modifications are being made to the reporting processes, as well as training and education for stakeholders statewide.

The Pennsylvania Medical Society (PAMED) has developed a suite of materials to help physicians understand the child abuse law changes. You can access the materials at www.pamedsoc.org.

Under the amended CPSL, all physicians seeking to renew their license on or after Jan. 1, 2015, will need to complete two hours of approved training on child abuse recognition and reporting as a condition of licensure.

The College of Physicians of Philadelphia SECTION ON MEDICINE AND THE ARTS

is pleased to announce a
POETRY COMPETITION

In Celebration of the Twenty-Fifth
Anniversary of National Poetry Month,
April 2015

The competition is open to students,
healthcare practitioners, educators and the
general public.

Poets are permitted one entry only that must
be postmarked no later than
January 15, 2015.

- The poem must be original, written in English, and must be relevant to medicine, health, or healthcare.
- All entries will undergo blind review by a qualified panel of judges led by prominent physician-poet Jack Coulehan, MD, MPH. Winning poems will be selected on the basis of craftsmanship, originality and content.
- The top three poets will be awarded \$500, \$250 and \$100 respectively and will be invited to read their poems at The College of Physicians on April 21, 2015. In addition, winning poems will be published on The College's website and in a chapbook that will be available through The College store.

For further details and to submit a poem, contact:

Rhonda L. Soricelli, MD, Chair, Section on
Medicine and the Arts
The College of Physicians of Philadelphia
RLSoricelli@comcast.net

Practices will begin to receive notice on 2015 PQRS Payment Adjustment

Is your medical practice at risk to receive negative payment adjustments in 2015 because you did not meet reporting criteria in 2013 for the Physician Quality Reporting System (PQRS)? Beginning Jan. 1, 2015, individual eligible professionals and group practices that did not meet PQRS reporting criteria will be subject to a negative payment adjustment of 1.5% to payments under the Medicare Physician Fee Schedule (PFS). If you believe the payment adjustment is being applied in error, CMS has instituted an informal review.

How to appeal a PQRS Negative Payment Adjustment

The Centers for Medicare and Medicaid Services (CMS) began notifying practices that will be affected by a negative payment adjustment of 1.5% in 2015 due to not meeting the reporting criteria in 2013 for the Physician Quality Reporting System (PQRS).

Physicians and other eligible providers should obtain a copy of their PQRS feedback report. Group practices participating in the PQRS Group Practice Reporting Option (GPRO) may obtain their feedback reports through the Quality and Resource Use Reports to review their reporting practices.

For those eligible professionals who believe the 1.5% payment adjustment is being applied in error, CMS has instituted an informal review process. Here are a couple of important points to keep in mind:

- You can request an informal review during the official time period starting Jan. 1, 2015, through Feb. 28, 2015. All requests must be submitted electronically through their communication support page.
- The appeals process is only for the 2013 PQRS reporting period from Jan. 1, 2013, through Dec. 31, 2013. It does not include ePrescribing, value-based payment modifier, or EHR reporting periods.

If you submit an appeal, CMS will notify you via email that your review request has been received and will be processed. You will be notified with the decision, again via email, within 90 days of submission.

All appeals decisions are final. There is not a second level appeal process.

Key physician contract issues: avoiding risk

By Karen Davidson

Compensation. Physician compensation models usually provide guaranteed base compensation for 1-2 years, after which compensation is subject to productivity based on targets.

Malpractice Insurance. There are essentially two types, namely claims-made and occurrence-based policies. To extend the coverage period of a claims-made policy an extended reporting period endorsement (tail) must be purchased. Tail coverage runs from 150%-200% of annual premium.

Term/Termination. Contracts often allow for termination by the employer on 60 or 90 days' notice for any reason (without cause termination). Physicians should consider the effect of an abrupt termination and ascertain if they are responsible for any expenses.

Non-Competition. These provisions, also known as restrictive covenants, are upheld in most states. They limit a physician from practicing within a geographic area for a specified period after the contract relationship ends. Time restrictions are typically 1-2 years. Geographic limits vary depending on locale. Physicians should assess the impact and consider limitations.

See the unabridged version at www.philamedsoc.org.

Karen Davidson is a healthcare attorney. She can be reached at 610-940-4041 or karend@md-healthlaw.com.



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