Dear MOCMS Members,

Greetings! I hope this newsletter finds you enjoying the fall in our beautiful county! Since our last newsletter there have been political changes both locally and nationally. I know when I voted I felt a deep sense of gratitude for living in a democracy. So many people fought hard over the years to win the right for all of us to vote. It felt good to exercise this right. It’s obvious that we have a membership that cares about current issues.

There was a good turnout for the Legislative Forum held on September 13th at the Bloomington Country Club (see pictures in the newsletter). There was a lively discussion and thoughtful disagreement on topics such as cigarette tax, LGBT rights, and the Affordable Care Act. Mike Rinebold, ISMA Director of Government Relations, encouraged members to stay in contact with their legislators over issues that impact the practice of medicine. In addition to the Legislative Forum, the MOCMS has hosted a number of other events to bring members together. I would like to highlight a few.

For the first time, MOCMS held a “New to Practice/New to Bloomington” event at Function Brewery. It was a nice way to get to meet others and share the joys and challenges of getting settled in a new community. Several in attendance suggested that we do this annually to welcome new medical staff MOCMS members.

Plans are in the works for another “Women in Medicine” meeting with leadership from Drs. Tashera Perry, Paula Bundy and Rachel Manley. Please contact them, if you have ideas for the focus of these gatherings. While just getting together seemed to be very beneficial, some issues of mutual interest could enhance the meetings even more.

On November 16th the Emeritus Physicians group met with Matt Bailey, new CEO of IU Health Bloomington Hospital, to discuss the future of the new hospital and other issues of concern during this time of transition.

I have enjoyed the opportunity to be the president of the Society for the last year and extend best wishes and thanks to Dr. Wes Archer who will take over as your new president and Dr. Sarah Hartung who will assume the role of president-elect of MOCMS, pending the vote (see enclosed ballot). Your Medical Society leadership is active and interested in providing the best possible programs and activities for you in 2017. Your communication and participation with these leaders is always welcome.

Sincerely,

Diana Ebling, MD
President
The 2016 Annual Convention of the Indiana State Medical Association was held in Indianapolis September 24-25. Your medical society was represented by Drs. Jim Faris, Clark Brittain, Carrie Davis, Caitilin Kelly, and me. I also attended the Board of Trustees meetings. This year’s convention featured a new 2-day condensed format, which streamlined the proceedings, particularly for the reference committee sessions. Despite strict time limits for comments, there was lively discussion on a number of resolutions. American Medical Association president Dr. Andrew Gurman was in attendance for the entire convention. Dr. Gurman was an active participant in Saturday’s reference committee proceedings and gave an update on the current status of the AMA strategic initiatives.

The work of the convention, in laying out the agenda for the coming year, centered around several important themes. Some of the associated resolutions and discussion are summarized below. A full listing of the resolutions, including the actions taken by the House of Delegates (HOD) is available on the ISMA website at: www.ismanet.org/go/ResActions.

One of the major topics of discussion was the report and resolution submitted by the ISMA New Directions Task Force. This task force was created to address issues of falling membership in the ISMA and county societies, and to identify ways to reorganize and revitalize the organization. Their report included a proposal for replacing the existing 13 districts (based on now-obsolete political districts from the 1930s) to 3 regions (North, Central, and South). After discussion throughout the convention, it was decided that a final configuration of 5 regions (2 regions in the north, 1 central region, and 2 regions in the south) would be preferable. It was left to the Board to decide on an appropriate division of the southern region. County medical societies would remain unchanged; however the composition of the board of trustees would be altered due to the smaller number of regional representatives. A map of the proposed change and table of changes to board composition is provided in the accompanying figure.

The house adopted several important resolutions regarding public health. These included a measure to address the current opioid epidemic through addiction treatment programs for jail inmates, improving the safety and security of needle/syringe disposal devices in medical facilities, improving opioid prescribing training for physicians, and working with state legislators to promote and fund a multifaceted drug abuse prevention program across the state. Tobacco abuse was addressed through a resolution to recommend raising the legal age for tobacco purchase to 21 years and another resolution recommending raising the tobacco tax by $1, with proceeds going toward tobacco cessation and addiction treatment. A resolution was also adopted as amended which proposed the ISMA issue a statement officially recognizing that pollution and environmental factors contribute to public health morbidity and mortality.

There were numerous resolutions considered regarding the health care system and healthcare finances and their impact on physician practices. These included working together with hospitals around issues of physician burnout, physician-hospital relationships and physician employment, addressing issues involving professional credentialing bodies, improving electronic medical records, and suggesting replacement or substantial revision of the Affordable Care Act. An important resolution impacting
Leaving Practice or Retiring Soon?

If so, please let MOCMS know where your medical records will be stored.

One of the most common phone calls received at the MOCMS office involves locating patient medical records for physicians who have moved or retired from practice. MOCMS keeps a database of that information for many physicians who have informed us, but certainly not for all former or current members. If your medical records are not housed at Storage Unlimited or with an ongoing practice from which you have retired, please contact the office to update that information for our database. You may email to director@mocms.org or call 812.332.4033. Thank you very much!

Did you know...

There is a “To Do” list you should complete before retiring or leaving practice from a risk management perspective.

- Notify your patients in advance to provide continuity of care and avoid abandonment claims. 60-90 days is recommended including information about who they may contact for care and where they can obtain their medical records. Newspaper notice is recommended, too.
- Safeguard the integrity of your medical records and the confidentiality of your patients’ health information by being sure appropriate arrangements have been made for custody of those records.

Before you close your doors:

- Be sure your current patients have appropriate arrangements for follow-ups on diagnostics and consults.
- Check with the state of Indiana concerning legal requirements for closing a practice and medical records retention.
- Need more information? Contact www.ismanet.org/legal/FAQ/all.htm

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<th>Divisions</th>
<th>Current</th>
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<tr>
<td></td>
<td>13 districts</td>
<td>5 regions*</td>
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<tr>
<th>Trustees</th>
<th>Current</th>
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<td>1 trustee + 1 alternate per district</td>
<td>2 trustees + 1 alternate per region</td>
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* The House recommended the Board discuss and decide on how to divide the southern region into 2 regions (which would make 5 total regions).
The Opioid Crisis and Your Practice

Everyone is aware of the crisis the state of Indiana and, in fact, the country is facing when it comes to overuse and abuse of pain medication leading to addiction. In the Surgeon General’s Report on Alcohol, Drugs and Health released on 11.17.2016, Dr. Vivek Murthy predicts that 1 in 7 in the USA will suffer from addiction. Statistics show that an American dies every 19 minutes from opioid or heroin overdose. Additionally, it was estimated that the economic impact of drug and alcohol misuse and addiction amounts to a cost of $442 billion annually.

In an appeal to physicians, Dr. Murthy recently wrote a letter asking for the help of all physicians to begin to solve this urgent health crisis facing America. After explaining some of the reasons for the crisis, Dr. Murthy made the following request:

“I am asking you to pledge your commitment to turn the tide on the opioid crisis. Please take the pledge. Together, we will build a national movement of clinicians to do three things:

■ First, we will educate ourselves to treat pain safely and effectively. A good place to start is the TurnTheTideRx pocket guide with the CDC Opioid Prescribing Guideline.

■ Second, we will screen our patients for opioid use disorder and provide or connect them with evidence-based treatment.

■ Third, we can shape how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing.”

This appeal was followed by an open letter from AMA President Steven Stack, MD, outlining his suggested measures physicians can take to curb the tides of this exploding epidemic:

“As a practicing emergency physician and AMA president, I call on all physicians to take the following steps—immediately—to reverse the nation’s opioid overdose and death epidemic:

■ Avoid initiating opioids for new patients with chronic non-cancer pain unless the expected benefits are anticipated to outweigh the risks. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred.

■ Limit the amount of opioids prescribed for post-operative care and acutely-injured patients. Physicians should prescribe the lowest effective dose for the shortest possible duration for pain severe enough to require opioids, being careful not to prescribe merely for the possible convenience of prescriber or patient. Physician professional judgment and discretion is important in this determination.

■ Register for and use your state prescription drug monitoring program (PDMP) to assist in the care of patients when considering the use of any controlled substances.

■ Reduce stigma to enable effective and compassionate care.

■ Work compassionately to reduce opioid exposure in patients who are already on chronic opioid therapy when risks exceed benefits.

■ Identify and assist patients with opioid use disorder in obtaining evidence-based treatment.

■ Co-prescribe naloxone to patients who are at risk for overdose.

A notice was then sent by Terri Marcheri, AMA Director of Federation Relations, requesting physicians to share the measures they are taking in their practices in response to the crisis.

"In light of the opioid epidemic and with physicians taking much of the blame in national media, the AMA has been highlighting what physicians are doing to reduce the stigma that surrounds substance use disorders, ensure safe prescribing practices, and have meaningful conversations with their patients about substance use disorders and access to naloxone. These articles are meant to show other physicians that what they are experiencing on the front lines of the epidemic is not unique to their practice—in other words, they’re not alone.

We would like to take this one step further. Our hope is to interview and gather useful information from physicians who are on those front lines treating their patient every day and who have changed the way they approach these issues to be a part of the national effort to end this epidemic.”

MOCMS member Rick Weidenbener, MD, wrote the following in reply to the request from Terri Marcheri. His remarks are the opinion of Dr. Weidenbener that he has given permission for MOCMS to share and do not reflect an endorsement of the Medical Society on this issue. The full content of the letters from Drs. Murthy and Stack can be found on our website www.mocms.org.

Dear Ms. Marchiori,

Your recent initiative is a good start but the use/abuse of opioids can be stopped at its source. First and foremost the 1-10 pain scale used at most hospitals should be abolished. It is purely subjective and MUST be removed as a “vital sign”. Vital signs can be measured (temperature, HR, pulse, respiratory rate), pain cannot. I have had patients with a broken femur tell me their pain is 3/10 and others with a simple ankle sprain tell me it is 10/10 (while they walk down the hall for an x-ray with barely a limp!). I NEVER ask a patient to rate their pain but on a follow-up visit I ask them what percent improvement they have seen. This makes it relative. Even the most marginally observant clinician can tell how much pain a patient is experiencing without a pain scale.

My suggestions for part of the re-training process:

■ Abolish use of the pain scale
Tell patients at the start that the pain medication is designed to REDUCED their pain and NOTHING will eliminate it completely. This manages expectations and pain reduction is usually accomplished at the prescribed dose and helps prevent overuse which of course leads to tolerance and addiction.

- Have clinicians be very disciplined about not giving refills early for those who take their opioids more often than prescribed.
- Encourage the establishment and frequent use of state programs that allow physicians to check to see if a given patient has received narcotics from more than one source (we make frequent use of the INSPECT program here in Indiana http://www.in.gov/pla/inspect/).
- Immediately cut off “double dippers” when discovered.
- Be clear to smokers that smoking greatly reduces pain tolerance and quitting is a must.
- Teach med students, interns, residents that if a patient volunteers that they “have a high pain tolerance”, IN GENERAL means that they usually have a low pain tolerance. This is a consistent observation of mine after 25 years of orthopedic practice. Patients who actually have a high pain tolerance RARELY mention it in my experience.
- Never give a replacement prescription to a patient who claims their pills were stolen unless he/she brings in the police report indicating such.

Thanks for listening,

Erich Weidenbener, MD
Final Requirements for MACRA from CMS


Additionally, those choosing the 90-day or full-year reporting options have the ability to qualify for incentives. Finally, the exclusion criteria were increased, allowing clinicians who see fewer than 100 Medicare beneficiaries OR submit less than $30,000 in Part B claims to be deemed ineligible.

Elements within the four MIPS buckets – Advancing Care Information (ACI), Quality, Cost, and Improvement Activities (IA) – have been altered significantly from the proposed rule as well. Requirements for reporting are based on the “pace” option selected by the clinician or group.

Final requirements for reporting year 2017 include those presented here.

Option 1 - Report all finalized requirements of MIPS for a 90-day reporting period or the full year to be qualified for a positive payment adjustment and avoid a negative payment adjustment. Exceptional performers may receive an additional positive adjustment for the first six years of MIPS, based on their performance.

Finalized requirements:
- Quality – Report on six measures (including one outcome measure) or one measures set (plus one outcome measure if none are included in the measures set).
- Cost – No reporting required.
- ACI – Report on the five required objectives from 11 total objectives for 50% of score.

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<tr>
<th>Required Objectives</th>
<th>Optional (may result in bonus points)</th>
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<tr>
<td>Security risk analysis</td>
<td>Report public health and clinical data registry reporting measures</td>
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<tr>
<td>e-Prescribing</td>
<td>Use certified EHR technology to complete certain measures in the improvement activities</td>
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<tr>
<td>Provide patient access</td>
<td>Send summary of care</td>
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<tr>
<td>Send summary of care</td>
<td>Request/accept summary of care</td>
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- IA – Attest for two high-weighted activities or four medium-weighted activities for a total max score of 40 points. Small, rural and Health Professional Shortage Area (HPSA) designated clinicians are required to achieve only a 20-point total.

Option 2 - Report to MIPS for a minimum of 90 days on either more than one quality measure, more than one IA or more than the five required ACI objectives to avoid the negative payment adjustment and possibly qualify for a positive payment adjustment.

Option 3 - Report one quality measure, report one IA or report the required amount of ACI measures (five) to avoid a negative payment adjustment. If no reporting from any of the categories occurs, 2019 Medicare Part B reimbursements will reflect a negative payment adjustment, - 4 percent.

Option 4 - Participate in an Advanced APM and receive a 5 percent bonus in 2019.

While CMS sought to reduce the reporting burden of multiple existing initiatives (MU, PQRS, VBPM), the resulting 2,400 pages of law offer much to digest.

Purdue Healthcare Advisors (PHA) is presenting a series of FREE webinars to help groups determine the right reporting option for their situation and to understand appropriate next steps. If you have more questions, contact ISMA at 317.261.2060.
Burnout Happens – Have You Checked Your Wellbeing?

Burnout occurs when passionate, committed people become deeply disillusioned with a job or career from which they have previously derived much of their identity and meaning. It comes as the things that inspire passion and enthusiasm are stripped away, and tedious or unpleasant things crowd in.

The AMA defines burnout as a long-term stress reaction characterized by depersonalization, including cynical or negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients.

Are you at risk? If you think you might be, there are several simple tests you can take to measure stress levels against others in your field. The ISMA offers a way to evaluate yourself at: [www.ismante.org/go/BurnoutTest](http://www.ismante.org/go/BurnoutTest). Two other easy-to-use tests include the Oldenburg Burnout Inventory endorsed by the British Medical Association found at [www.isma.org/go/BMA101016](http://www.isma.org/go/BMA101016) and Mind Tools for self-evaluation at [www.ismanet.org/go/MT101016](http://www.ismanet.org/go/MT101016).

Dike Drummond, MD, a Mayo-trained certified life and business coach, tackles the question of burnout in his blog at [www.thehappymd.com/blog](http://www.thehappymd.com/blog). Dr. Drummond's comments on burnout and possible cures can be found at [www.simaneet.org/go/HMD101016](http://www.simaneet.org/go/HMD101016). You can also find assistance with the AMA Steps Forward program which focuses on personal resilience.

If you find you are at risk, don’t stay in isolation. Reach out to a colleague, a friend or to MOCMS for confidential guidance toward treatment options and important resources. Your wellbeing matters!
PLEASE KEEP US UPDATED

In our increased effort to “go green”, MOCMS is hoping to communicate with you through email. If you would like to help MOCMS use less paper, please be sure we have your updated email address by sending an email to director@mocs.org and check that your spam blocker will allow communications from MOCMS.

Please check your office information listing on our website at www.mocs.org under “Find a Physician” and send corrections to director@mocs.org.

MOVED LATELY?

Please forward your new address for your home or your practice to us immediately. You may call MOCMS at 812.332.4033, write to us at PO Box 5092, Bloomington, IN 47407-5092 or email: director@mocs.org. Please help us keep your information current/correct in the MOCMS database, physician directory and on our website at www.mocs.org.