MSSNY Kicks Off Menengitis Awareness
MSSNY’s William Spencer, MD addressed a June 12 press conference to kick off Meningitis B Awareness Week. MSSNY hosted the press conference in its Westbury offices in partnership with the Kimberly Coffey Foundation to urge parents to vaccinate their children to prevent Meningitis B, a potentially deadly, but preventable disease. Both the New York State Senate and the New York Assembly recently declared June 12-16 Meningitis B Awareness Week. “The importance of vaccines begins in infancy and continues right through adulthood and MSSNY is committed to ensuring that all indi-

(Continued on page 9)

DOH Attestation Process for Pain Management CME Must Be Completed by July 1, 2017
The New York State DOH has announced the attestation process for prescribers required to complete Pain Management CME. Prescribers must attest to the completion of the pain management, palliative care and addiction course work or training by July 1, 2017, and again every three years thereafter. The prescriber should only attest after completion of at least three hours of course work or training covering all eight topics. A prescriber with a Health Commerce System (HCS) account will attest online using the Narcotic Education Attestation Tracker (NEAT) application.

(Continued on page 9)

Need to Meet Your Pain Management CME Requirement?
MSSNY Pain Management, Palliative Care and Addiction Online Program Available
The Medical Society of the State of New York Pain Management, Palliative Care and Addiction modules are now available on-line here.
These modules are being offered free of charge to all MSSNY members. Physicians who are new users to the MSSNY CME site will be required to register as a new user. As a new user, physicians and non-physicians will be required to enter fields that include: position; name (the name should be what you want to appear on the CME certificate); email

(Continued on page 11)

MSSNY-PAC
Dear Physicians:
As you may be aware, the State Legislature ended its formally scheduled 2017 Legislative Session late Wednesday, June 21 (though it is possible for them to return to Albany on a limited basis). Despite being besieged with numerous adverse proposals in the final weeks of Session, we are happy to report that the Session ended with MSSNY, working together with many other allies, able to assure that the scores of the adverse legislative proposals were rejected, including legislation that would have:
- Enabled corporate-owned Retail Clinics staffed by physician extenders
- Significantly expanded the information required to be included in the Physician Profile
- Limited injured worker choice of physician in Workers Compensation, expanded the role of Non-Physicians under Workers Compensation, and eliminated the county medical society role in processing applications
- Imposed burdensome new requirements on the prescribing of pain medications to patients;
- Required urgent care office-based surgery centers to use electronic health records
- Expanded the scope of practice of numerous non-physicians, including podiatrists, Nurse-anesthetists, optometrists, psychologists, chiropractors, and naturopat-

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INSIDE NEWS
Yes, doctors really do dismiss patients
....................page 2
MSSNY helps you recover claims for free!
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Burnout is caused by insurance problems!
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New 2018 Medicare cards have no SSN #s
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CLICK ICONS TO FOLLOW MSSNY ON FACEBOOK OR TWITTER.
Paid Family Leave Benefits Begin in 2018; Payroll Deductions Begin in July 2017

All physician employers should be aware that, beginning January 1, 2018, their employees who have worked for 26 or more consecutive weeks (or part-time for at least 175 days) will be eligible for Paid Family Leave (PFL), as a result of legislation enacted last year as part of the 2016-17 State Budget. Employees will be eligible to receive up to 8 weeks of paid leave in 2018, with this amount going up to ten weeks in 2019 and 12 weeks in 2021.

Premiums for the PFL program are fully funded through employee payroll contributions.

Employees are eligible for PFL benefits for a) maternity or paternity leave for birth of a child, b) caring for a close relative with a serious health condition or c) when a spouse, child, domestic partner or parent of the employee is on active duty or has been notified of an impending call or order of active duty.

Employers may begin to withhold the weekly employee contribution beginning July 1, 2017, for the coverage that begins on January 1, 2018.

For more information from New York State about this new program click here. For additional online summaries about this new law, click here and here.

Doctors Do Dismiss Patients for Difficult or Inappropriate Behaviors

Nine out of 10 health care provider practices have “fired” a patient because of poor patient behaviors, according to research published in JAMA Internal Medicine. According to the researchers, the findings show that physicians are not dismissing patients because of particularly difficult or complex medical issues as insurers shift from fee-for-service reimbursement toward value-based payments. “The reasons practices are dismissing patients aren’t so much related to the things people were worrying about — that if [insurers reimburse more for] quality of care, doctors might start cherry-picking patients,” said Dr. Ann O’Malley, Mathematica Policy Research senior fellow and lead author.

Among the reasons the nearly 800 practices surveyed gave for cutting ties with a patient:

- Violent, “disruptive,” or inappropriate behavior toward doctors or staff
- Violation of policies related to chronic pain and controlled substances
- Failure to show up to scheduled appointments
- Repeated disregard of a doctor’s medical recommendations
- Violation of bill payment policies

MSSNY Members Only: Unpaid Claims We Can Help!

In 2016, MSSNY’s Ombudsman Program was successful in recovering $89,815.79 for physicians who had reached a stalemate regarding unpaid claims. From January to June of 2017, the program recovered $121,441.68 for our members who availed them of the Ombudsman service.

If you are a member in good standing, this service is available to you for FREE!

For further information, call 516-488-6100 ext 334 or 332.
Choosing medical liability insurance is about trust. Knowing that you have the resources, guidance and expertise to support you...today and tomorrow. So, at a time when others are struggling, MLMIC stands strong, and you can count on this:

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- Unparalleled claims, risk management and legal services
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SAVE 20%
when you are insured by May 1st

*The 20% dividend applies to policyholders insured on May 1, 2017 and who maintain continuous coverage through July 1, 2017 and is based upon the annual rate of premium in effect on May 1, 2017.*
Statement from MSSNY President, Charles Rothberg, MD
Re: Statute Of Limitations Expansion Bill

New York’s physicians are extremely concerned about the ultimate impact to New Yorkers’ access to care if the statute of limitations expansion bill (S.6800/S.8516) considered by the Legislature today were ultimately signed into law. Many New York hospitals and physicians are already struggling to keep their doors open.

New York State has already earned the dubious distinction as the absolute worst state in the country in which to practice medicine, in large part due to its overwhelming liability costs. The bill will add significantly to these costs that have already driven physician after physician out of private practice, and in many cases driving them out of New York altogether. It will also discourage countless others from coming here to practice.

We urge Governor Cuomo to veto this legislation and to then bring parties together to pass comprehensive, not one-sided medical liability reform.

New Yorkers’ access to health care is at stake.

NYS DOH Launches “Provider & Health Plan Look Up:” Check ASAP for Errors

The New York State Department of Health, together with the NY State of Health, this week announced the launch of the NYS Provider & Health Plan Look-Up, an online tool that consumers can use to research those health insurance plans with which a physician (and other health care practitioners) participates. It also lists practice locations for each physician. Previously, a consumer would have to go to the website of each health insurance company to determine if a physician participated with a particular plan.

Physicians should take the opportunity to go to the website to see which health plans they are listed to participate with to determine if there are inaccuracies in their listings.

According to a recent MSSNY survey, over 50% of responding physicians indicated that they were inappropriately listed as a participating provider on a health insurer’s website. One physician who contacted us reported that he was listed as having 167 practice locations! The most efficient way to report an error is for the physician or someone on his or her behalf to select the Contact Us button on the website. Then select the health plan and the reason for the contact. The issue will be routed electronically to the DOH and to the selected health plan(s) for review and follow-up.

This newly created DOH website is strictly limited to those physicians who have contracts to participate in a health plan’s network. If you participate in ONLY traditional fee for service Medicare/Medicaid or only in academia, this website is not for you! If you cannot locate your name on your initial search, please be sure to enter the county where you practice.
New Medicare Cards Will No Longer Contain Social Security Numbers

CMS is readying a fraud prevention initiative that removes Social Security numbers from Medicare cards to help combat identity theft and safeguard taxpayer dollars. The new cards will use a unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI), to replace the Social Security-based Health Insurance Claim Number (HICN) currently used on the Medicare card. CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019. Health care professionals and beneficiaries will both be able to use secure look up tools that will support quick access to MBIs when they need them. There will also be a 21-month transition period where providers will be able to use either the MBI or the HICN further easing the transition.

CMS will assign all Medicare beneficiaries a new, unique MBI number which will contain a combination of numbers and uppercase letters. Issuance of the new MBI will not change the benefits a Medicare beneficiary receives.

CMS has a website dedicated to the Social Security Removal Initiative (SSNRI) where providers can find the latest information and sign-up for newsletters. CMS is also planning regular calls as a way to share updates and answer provider questions before and after new cards are mailed beginning in April 2018. For more information, please visit here.

What is the Status of the New CMS Primary Care Payment Initiative?

Last summer, the CMS announced a new initiative intended to improve payment for primary care. The program, called “Comprehensive Primary Care Plus” (“CPC+”), was begun in 14 regions, including 11 whole states. In this area, it included all of New Jersey, the North Hudson Valley in New York and the Greater Philadelphia area in Pennsylvania.

These areas were selected on the basis of density and interest shown by providers and payers. Under CPC+, providers are to be paid a monthly fee for primary care visits.

The new markets to be added include the Greater Buffalo Region in New York, encompassing Erie and Niagara Counties, as well as Louisiana, Nebraska and North Dakota. No reasons have been given for the apparent lack of interest in this initiative, which resulted in it being rolled out in fewer new markets than anticipated.

The initiative is intended to improve outcomes and lower costs. The initiative has two tracks—under track one, providers receive a monthly fee for specific services, in addition to fee-for-service payments. Under track two, providers will receive an upfront monthly care management fee and reduced fee for service payments.

This is intended to allow providers to offer care outside of traditional face to face encounters. Depending upon the volume of patients, providers could potentially earn an additional $100,000 to $250,000 per year under the model. The model was supposed to launch in up to 20 regions, but CMS saw less interest than was expected, and this pattern has held when the program was recently expanded.

CMS has a number of events coming up that might be of interest; dates, times and registration information can be found here. CMS also has two short videos that provide helpful information about the model:

- CPC+ Care Delivery Transformation Video
- CPC+ Payment Innovations Video

CMS has stated that if any of the organizations would like to talk directly about the model, they would be happy to set up some time. Please contact Regina McNally at rmcnally@mssny.org or 516-488-6100 ext. 332 if you would like to arrange a meeting/phone call with CMS subject matter experts.

New Yorkers Living Longer

The new Summary of Vital Statistics revealed other signs that New Yorkers are living healthier lives.

- New Yorkers are living 1.5 years longer than a decade ago and nearly nine years longer than 25 years ago, city Health Department data show.
- City residents’ life expectancy extended to 81.2 years in 2015, the most recent year for which data is available. In 1990, it was just 72.4 years.
- City women could expect to live 83.5 years, the data showed, five years longer than men (78.6). With a life expectancy of 82.4 years, city Latinos live on average a year longer than whites (81.3) and five years longer than blacks (77.3). The city did not report the rate for Asians.
- The mortality rate for city residents decreased by 16 percent from 2006 to 2015. It fell 19 percent for those under age 65 as fewer succumbed to heart disease, cancer and other illnesses.
- Teen birth rates plummeted 47 percent since 2006, and the city’s infant-mortality rate plunged 27 percent in the same period.

Agencies Warn of Faulty Blood Tests for Lead, Recommend Retesting

Some blood tests made by Magellan Diagnostics may falsely report low lead levels in children and adults, the FDA and CDC cautioned recently. The FDA is warning against using Magellan Diagnostics LeadCare analyzers with venous blood samples. The alert doesn’t apply to blood collected by finger- or heelstick.

Children currently younger than 6 years need to be retested if they had venous blood samples analyzed with any of the following Magellan products — LeadCare, LeadCare II (which is used in provider offices and clinics), LeadCare Plus, or LeadCare Ultra — and their results were 10 µg/dL or less. Pregnant and nursing women should also be retested.

The problem with falsely low readings began as far back as 2014, the FDA said. For more information: FDA news release; CDC health advisory.
In May of 2016, the MSSNY created a Stress and Burnout Task Force. This Task Force was charged to formulate a strategy and plan of action to fight burnout and reduce stress among the constituents of the MSSNY. The following article is the first of a miniseries that will address the following topics: the problem of burnout, current state of the State (burnout survey), solutions at the individual and organizational level, and opportunities for collaboration and advocacy.

INTRODUCTION AND DEFINITION

Physicians and other healthcare professionals are the proximal reason for the quality of care provided to patients. What effect does increasing high-level and chronic occupational stress imposed from multiple uncoordinated sources have on them personally and ultimately the patients they serve? There is overwhelming evidence that the effect is devastating, but the level of awareness of this fact is slow to be recognized by the clinicians, the healthcare systems, and the sources of the stress.

Burnout is defined as a psychological syndrome involving emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (1). Each one of these definition criteria can have deleterious effects on the provider-patient interaction as shown in table 1.

The human condition of burnout is the same across many healthcare professions, but the specific stressors differ by profession. This article will focus upon physician burnout as a personal and public health issue, calling the question to reassess the best use of resources and better understanding the forces involved.

AN INCREASINGLY RECOGNIZED EPIDEMIC FORGES A REFOCUS ON THE EXPERIENCE OF PROVIDING CARE

The widespread problem of physician burnout has made it into many press outlets including the New York Times, Time, US News and World Report, and Forbes to name a few. Our patients know we are going through this dilemma as a group and now so do health care institutions.

From the period of 2011 to 2014, burnout in physicians rose from 46% to 54% while burnout in the general population remained about the same. Work/life balance went up in the general population and decreased in physicians during the same time (2).

The forces involved in the creation of burnout are often considered nebulous, sometimes subterranean because they are an accumulation of a massive number of factors. Our own medical culture of endurance and somewhat super-human internal perceptions of ourselves and external perceptions others have of us have contributed to the delays in awareness of how stressful and toxic the healthcare work environment has become. As author Dike Drummond MD states: “It’s not a fair fight” as a final acknowledgement that in total, the job description has become actually impossible to achieve. He also describes the multiple factors as “death by a thousand paper cuts” as an imagery to try to understand.

Table 1.

<table>
<thead>
<tr>
<th>Burnout Criteria</th>
<th>Effect on Staff-Patient Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>Delay of needed interactions with patient</td>
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<tr>
<td></td>
<td>Less tolerance, irritability</td>
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<tr>
<td></td>
<td>Not much left to give</td>
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<tr>
<td></td>
<td>Decreased Patient Satisfaction</td>
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<tr>
<td>Depersonalization/ Callousness</td>
<td>Withdrawal from patient</td>
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<td></td>
<td>Decreased compassion</td>
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<tr>
<td></td>
<td>Decreased listening to patient</td>
</tr>
<tr>
<td></td>
<td>Increased cynicism and sarcasm</td>
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<tr>
<td></td>
<td>Increased risk of patient-on-staff workplace violence</td>
</tr>
<tr>
<td>Decreased Efficacy</td>
<td>Poor occupational confidence</td>
</tr>
<tr>
<td></td>
<td>Think making poor decisions</td>
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<tr>
<td></td>
<td>Later, actually making poor decisions</td>
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<tr>
<td></td>
<td>Cognitive Flexible Memory (CFM) switches to Habit Memory (HM) causes less</td>
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<tr>
<td></td>
<td>differential diagnosis and poorer care plan</td>
</tr>
<tr>
<td></td>
<td>HM: Reflex responses to stimuli—survival mode</td>
</tr>
<tr>
<td></td>
<td>Cognitive impairments of decreased executive function: Decreased</td>
</tr>
<tr>
<td></td>
<td>attention, focus, situational awareness, long term perspective, ability</td>
</tr>
<tr>
<td></td>
<td>to anticipate patient and family needs &amp; other patients on unit</td>
</tr>
</tbody>
</table>
Michael R. Privitera, MD  Chair, MSSNY Physician Stress and Burnout Task Force

Physician Burnout as an Individual and Public Health Issue: The Need to Reassess Best Use of Resources

Fouad Atallah, MD  Director of Patient Safety, Department of Obstetrics and Gynecology, Maimonides Medical Center, Brooklyn NY

Director, Medical Faculty and Clinician Wellness Program

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major problem—is superficially justified by the fact that plenty of burnout resilience or as an external/organizational problem in which an/individual problem that can be solved by better selection and training of healthcare workers and 2) internally: over-expectation of human capabilities by the healthcare workers themselves. Two publications on The Quadruple Aim framework (5, 6) include the fourth aim – improving the experience of providing care-such that the healthcare workforce of physicians, nurses and employees find joy and meaning in their work. This framework addresses the human factors in the delivery of care that are essential to the success of the other three aims of patient experience, cost, and quality of care.

A SPECIFICALLY VULNERABLE POPULATION: PHYSICIANS IN TRAINING

College graduates who are enrolled into medical school have lower burnout and depression ratings than the general population. Two years in medical school, this group has higher burnout and higher depression than general population (7). At the beginning of internship before it starts, the incidence of depression is about 3.9%. Three months into internship it becomes over 6 times higher at a rate of 27.1% and stays high throughout internship (8). Suicidal ideation before internship is at 2.5%, at 3 months becomes 4.0%, at 6 months becomes over four times higher at 11.1% and stays high throughout the rest of into internship (9). We also know that acute and chronic depression can affect medical decision making increasing the rates of errors. We need to examine what we are doing to these humans in both the educational experience and early work experience as a physician.

WHAT ARE THE WORK-RELATED STRESSORS THAT CONTRIBUTE TO BURNOUT?

At the extremes, burnout can be viewed either as an internal/individual problem that can be solved by better selection of physicians, mindfulness and yoga practice, and enhancing resilience or as an external/organizational problem in which burnout is equated with abuse and organizations are the main culprit. Evidently, these polarized views are too simplistic. Six categories of work stress have been identified to contribute to burnout (10):

1. Excessive workload: physical, cognitive, or emotional.
2. Lack of control in being able to influence work environment.
3. Poor balance between effort and reward.
4. Lack of community: or of a culture of mutual appreciation and team work (This gets worse the busier the physician becomes).
5. Lack of fairness in resources distribution.
6. Value conflict: the stress of having to participate in sub-optimal unethical circumstances.

Of note, a denialist view of burnout—that burnout can’t be a major problem—is superficially justified by the fact that plenty of people still go to medical school and doctors still show up for work. If physicians for a moment go back to their pre-med experiences and the motivating factors to become a physician, it becomes fairly clear that becoming a physician is a calling and not a series of transactions that may be the focus of the business of medicine. This dissonance needs to be better acknowledged and reduced, but is beyond the scope of this article.

THE IMPACT OF CLINICIAN BURNOUT IS COSTLY

There are multiple dose-related relationships such that the higher the burnout the higher the incidence.

Institutional and patient toll:
- Increased medical errors and malpractice claims.
- Disruptive behavior.
- Reduced empathy for patients, patient satisfaction.
- Reduced patient adherence to treatment regimens.

Financial Toll:
- Reduced in-patient satisfaction scores.
- Major contributor to turnover costs.
- Increased medical claims by employees.
- Major contributor to short-term and long-term disability costs.

Personal Toll:
- Reduced career satisfaction.
- Higher Suicide Rate among physicians (about 400/year).
- Substance abuse.
- Divorce.
- Coronary Heart Disease.
- Depression.

MECHANISMS OF IMPACT, THE CASE FOR BIOLOGICAL PLAUSIBILITY

Physicians are trained to use what they have learned for medical decision making (MDM). The prefrontal cortex (PFC) is the part of the physician’s brain that (together with widespread neuronal networks) is responsible for executive function (EF). EF weighs the multiple factors at hand to make the best diagnosis and treatment plan and is a limited resource. EF includes the ability to manage time, attention, switch focus, plan and organize, remember details, curb inappropriate behavior and speech, and integrates past experience (e.g. medical training) and experiences with present needed action to practice medicine of the highest competence. PFC is the most evolved brain region and subserves our highest-order cognitive abilities. Unfortunately, it is also the brain region that is most sensitive to the detrimental effects of stress exposure. Even quite mild acute uncontrollable stress can cause a rapid and dramatic loss of prefrontal cognitive abilities, and more prolonged stress exposure causes architectural changes in prefrontal and amygdala nerve cells. This constant prioritization processing induced by uncoordinated mandates and subsequent diminished attentional resources available then increases “goal shielding” that attempts to help the doctor filter out other factors and get overly narrow in focus. Over-focus on specifically allocated task-relevant processing (for example, making sure all the Meaningful Use in the electronic record are noted as “marked as reviewed” by properly clicking the appropriate buttons), then detract from cognitive flexible memory (CFM) needed in the clinical moment with the patient needed to weigh factors at hand. Habit memory (HM) then predominates over CFM that would have been used to examine factors in more accurate diagnosis, more comprehensive and effec-

(Continued on page 16)
Erie County Medical Society Elects New Officers

Willie Underwood III, MD, a urologist with Roswell Park Cancer Institute, Buffalo, is the new President of the Erie County Medical Society. He was installed at the Society’s Annual Meeting on May 25 at Statler City. He succeeds Timothy F. Gabryel, MD.

Dr. Underwood came to RPCI from Wayne State University and Karamanos Cancer Institute in Detroit, MI. He earned his Medical Degree in 1994 from SUNY Upstate, and completed his residency training in General Surgery in 1996 and Urology in 2000 at the University of Connecticut Health Center, Farmington, CT. He completed the Robert Wood Johnson Clinical Scholars Program in 2002 at the University of Michigan, Ann Arbor, and served as Assistant Professor in Urology from 2002 to 2005. He is certified by the American Board of Urology.

Dr. Underwood’s research interests include factors influencing the racial treatment disparities in, and novel therapies for prostate cancer. His research has been funded by the NIH/NCI as well as the Robert Wood Johnson Foundation and the AUA. He has been selected as the “Rising Star” in urology by the American Urological Association Foundation. He was appointed by the AMA Board of Trustees to the Council on Legislation, which serves to advise and provide input regarding all healthcare legislation at a federal and state level. He also serves on the AUA’s Health Policy Council and Legislative Affairs Committee.

Officers, Committee Chairs and MSSNY Delegates Installed

Officers: John Gillespie, MD, President-Elect; Kenneth H. Eckhert III, MD, Vice President; and Stanley J. Pietrak, MD, Secretary/Treasurer. All will serve a one-year term.

Chairs of the standing committees (one-year terms): Gordon P. Tussing Jr., DO, Practice Management; Rose Berkun, MD, Legislation; Iris R. Danzinger, MD, New Physician Practice; Gale R. Burstein, MD, Public Health

Ethics Committee (three-year terms): JoAnne Cobler, MD, Richard Ruh, MD, and Irene Snow, MD.

Nominating Committee (three-year terms): Christian Chouchani, MD, Julie Madejski, MD, Robert Powalski, MD, and Valerie Vullo, MD.

Delegates to MSSNY’s House of Delegates (two-year term): Ernesto Diaz Ordaz, MD, Chair-Elect; Richard Buckley, MD, Eugene Kalmuk, MD, and Richard Ruh, MD.

Alternate Delegates to MSSNY’s House of Delegates (two-year term): Jodi S. Ball, MD; Todd L. Demmy, MD; Eric J. Koch, MD; and Michael P. Rade, MD.
Expired EpiPens May Still Contain Effective Doses of Epinephrine

In a small study published in the *Annals of Internal Medicine*, researchers analyzed the contents of 31 EpiPens and 9 EpiPen Jrs that had expired in the prior 1–50 months. None had developed discoloration. Roughly 65% of the EpiPens and 56% of the EpiPen Jrs still had at least 90% of the labeled concentration of epinephrine. An EpiPen that had expired 50 months earlier still had 84% of the stated amount of epinephrine.

The authors conclude: “Although we observed declining concentrations of epinephrine over time, we expect that the dose available 50 months after expiration would still provide a beneficial pharmacologic response. Thus, we conclude that the process for establishing expiration dates for EpiPens should be revised and that, in the setting of outpatient anaphylaxis without other therapeutic alternatives, patients and caregivers should consider the potential benefits of using an expired EpiPen.”

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Grocery store and gas bonus rewards apply to the first $1,500 in combined purchases in these categories each quarter.*

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Use Priority Code VACN54.

Menengitis

(Continued from page 1)

Individuals receive immunizations,” said Dr. Spencer, a Pediatric Otolaryngologist and Suffolk County Legislator (18th District). “In 2015, MSSNY helped to successfully advocate for a law that required children entering 7th and 12th grades in all public and private schools in New York State be fully vaccinated against meningococcal disease types A, C, W and Y in order to attend school. The law does not require immunization of the Serogroup B meningococcal vaccine, but this vaccine is available for teens and young adults.”

DOH Attestation Process

(Continued from page 1)

Complete the steps to access the NEAT (Narcotic Education Attestation Tracker) application in the NYS Health Commerce System (HCS):

1. Log into the HCS Under “My Content” click on “All Applications”
2. Click on “N”
3. Scroll down to NEAT (Narcotic Education Attestation Tracker) and double click to open the application. You may also click on the “+” sign to add this application under “My Applications” on the left side of the Home screen.

Complete the steps to ATTEST to the completion of the education requirement. A full set of instructions can be found [here].

Prescribers that do not have access to a computer can request a paper attestation form by calling the Bureau of Narcotic Enforcement (BNE) toll-free at 1-866-811-7957. They may then complete the form and return it by mail to the address provided in the form. The Bureau of Narcotic Enforcement has also released a Frequently Asked Questions (FAQs) on the prescriber mandate. A copy of the FAQs can be found [here].

In certain limited circumstances, the New York State Department of Health may grant an exemption to the required course work or training to an individual prescriber who clearly demonstrates to the department that there is no need to complete such training. Exemptions will be granted only in very limited circumstances, and not solely on the basis of economic hardship, technological limitations, prescribing volume, practice area, specialty, or board certification. Prescribers may apply for an exemption through the Health Commerce System. Further information may be obtained by contacting BNE at 1-866-811-7957 or narcotic@health.ny.gov.

Menengitis

(Continued from page 1)

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For information about the rates, fees, other costs and benefits associated with the use of this Rewards card, or to apply, go to the website listed above or write to: PO Box 15020, Wilmington, DE 19850. The 2% cash back on grocery store purchases and 3% cash back on gas purchases applies to the first $1,500 in combined purchases in these categories each quarter. After that the base 1% cash back applies to these purchases.

† You will qualify for $100 bonus cash rewards if you use your new credit card account to make any combination of Purchase transactions totaling at least $500 (exclusive of any fees, returns and adjustments) that post to your account within 90 days of the account open date. Limit one (1) bonus cash rewards offer per new account. This one-time promotion is limited to new customers opening an account in response to this offer. Other advertised promotional bonus cash rewards offers can vary from this promotion and may not be substituted. Allow 8-12 weeks from qualifying for the bonus cash rewards to post to your rewards balance.

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Joseph R. Sellers, MD (Schoharie)
Zebulon Charles Taintor, MD (New York)
Kern Augustine PC

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Need to Meet Your Pain Management CME Requirement?

(Continued from page 1)

address; and then create a password. MSSNY members who encounter a payment page or have difficulty registering, please email cme@mssny.org for technical support. Directions for creating a new account/or logging in can be found here. Non-MSSNY physicians will be charged $50 per module.

The MSSNY CME is a new site and while many MSSNY members have an account with mssny.org a MSSNY member may not necessarily have an account with cme.mssny.org. If in doubt, try to create an account and if it tells you that the email address is unavailable or in use, an account exists. Passwords can be reset if you don’t know it. Physicians who have previously had an account at the MSSNY CME site will need to log into the site using their email and password. The MSSNY CME site provides the ability for physicians and other subscribers to view the archived webinar at their leisure, take the required test, and download their certificate. The online program covers all eight topics required in the New York State statute. MSSNY developed the program with the NYS Office of Alcoholism and Substance Abuse Services (OASAS). MSSNY is listed as an accrediting organization by the NYS DOH Bureau of Narcotic Enforcement. Information on the three CME modules is available here. Additional information or technical support may be obtained by contacting cme@mssny.org.

NYS DOH Expands HIV Testing Website

The New York State DOH announced the release of its newly designed New York State Expanded HIV Testing website at www.NYSEHT.org. DOH has streamlined its site to better serve hospital and clinic administrators and New York State clinical providers. Physicians are encouraged to visit the site and refer to it for all routine HIV testing questions and needs.

Additionally, physicians are invited to partake in a research study entitled “Usability and Evaluation of the NYS Expanded HIV Testing Website,” conducted by the University of Rochester and the New York State DOH. The purpose of the study is to help DOH understand practicing providers’ current HIV testing practices.

DOH will use this information to address potential gaps in routine HIV testing. This study involves an on-line survey that should take no more than three minutes to complete. To learn more about the study or complete the survey, click here. If there are additional questions or need assistance to complete the survey, please email the study coordinator at: margaret_demment@urmc.rochester.edu. Physicians will receive up to two follow-up emails about participating in this study.

Say Goodbye to Your Prescription Pad

Comply with New York’s I-STOP and E-Prescribe Legend and Controlled Drugs with the Official E-prescribing Solution of MSSNY.

DrFirst and MSSNY have partnered to bring MSSNY members the industry’s leading e-prescribing solution at a special discounted price. DrFirst’s Rкопia® and EPCS Gold™ 2.0 will help New York providers improve patient safety, comply with I-STOP, and prescribe legend and controlled drugs in a single, web-based workflow.

To get started and receive your special MSSNY member discount visit www.DrFirst.com/mssny or call us at 866-980-0553.
When the Auditor Comes Knocking, Will You Be Ready?
By: Jacqueline Thelian, CPC, CPC-I, CHCA
Medco Consultants, Inc.

There are many types of audits. Some are relatively benign, while others bring about a fair amount of anxiety. In either case knowing how to navigate the process helps to not only alleviate anxiety but to ensure the best possible outcome.

The first step in an audit process is to be able to identify the type of audit. Look at the letterhead and determine if the request for records is from an insurance carrier, Medicare or a third party contractor by an insurance carrier.

For example, an insurer may request records as part of a HEDIS review (Health Effectiveness Data and Information Set). The goal of a HEDIS review is to measure performance on various elements of healthcare services. The letter will generally state this as the reason for the review. Some types of reviews are conducted by approximately 90% of health plans and do not result in an overpayment demand.

On the other hand, a request for records from CMS Safeguard Services, or from a ZPIC (Zone Program Integrity Contractor) may have you reaching for the phone to call your healthcare attorney.

These audits are focused on documentation, coding and billing and usually end up with overpayment demands, extrapolations and in some cases prepayment reviews. The focus of a ZPIC audit is to identify fraud and abuse. ZPICs have the authority to turn the case over to the Department of Justice (DOJ) or the Office of Inspector General (OIG).

SUCCESS DEPENDS ON RESPONSE
Regardless of the type of audit the key to achieving a successful outcome is dependent upon how you respond.

The first step is to prepare complete records by making four sets of copies, one for each of the following, your office, the insurance carrier, your healthcare attorney and your coder. It is extremely important to keep copies of what was sent in. Your healthcare attorney and coder need to know exactly what the carrier is reviewing so they can determine the potential outcome of the audit prior to the carrier’s determination and get a jump start on the appeal process.

Be sure to send in all corresponding documents relating the request. For example, for any diagnostic test, the documentation should include any tracings, images, the order for the test establishing medical necessity and how the test results are being utilized in the treatment of the patient.

For any evaluation and management service (E/M) you want to include any laboratory and/or diagnostic testing results relative to the encounter. Make sure all notes are signed and dated by the provider of service. If submitting paper records ensure both the front and back of the note is copied and each page should include the patient’s name, another patient identifier (e.g. date of birth), and the date of service. Most importantly make sure you are sending in copies and not the originals.

Oftentimes the provider will send in only the date of service requested and wonder why the carrier asks for a refund. For example, records requested for a patient who had an epidural injection. In this case the medical necessity as well as the prerequisites (e.g. failure of conservative therapy) and the order are usually found in the patient’s progress note and not necessarily in the procedure note.

Another example would be nerve conduction testing. As per the Centers for Medicare and Medicaid Services (CMS) “The clinical history and examination carried out before the study, must always describe and document clearly and comprehensively the need for the planned test.” The documentation must also include how the test results are utilized in the treatment of the patient. Oftentimes this information is in the patient’s progress note and not on the testing results.

DO IT RIGHT THE FIRST TIME
Submitting the required documents the first time around can help to reduce the amount of denials, making your appeal less burdensome.

The appeal is the next step in the audit process. After documents have been submitted and the carrier has reviewed the records you will receive a letter and in some cases a report of the carrier’s findings. This is usually accompanied by a spreadsheet. This spreadsheet is of importance for Medicare appeals as it includes the following required fields necessary for an appeal:

- HIC# - Health Insurance Claim
- Patients Name
- ICN# -
- From Date & Through Date (Date of Service)
- Procedure Code
- Billing Provider’s Number
- Billed Amount
- Allowed Amount
- Paid Amount
- Paid Date
- Revised Allowed
- Revised Paid
- Refund
- Comments
- Reason Code
- POS – Place of Service
- Modifier
- Diagnosis code

ALWAYS REQUEST EXCEL FORMAT
If the spreadsheet is sent in pdf format always request it in excel format as this will dramatically reduce the amount of time you spend on your appeal.

The most effective way to send in an appeal is to add two additional columns to the spreadsheet to include your findings with the refund amount if any you feel is applicable.

For any line item where you disagree with the carrier’s determination, you want to include a copy of the documentation and highlight any pertinent information the carrier may have overlooked and include any supporting documents that might not have been sent in the first time. Never alter the documentation or add any written comments. The written comments should be documented on the excel spreadsheet.

You also want to include a narrative. The narrative should address each of the concerns identified by the carrier and why you disagree with their findings. It should also include the list of nationally recognized source documents (e.g. Local Coverage Determination, CPT Assistant) utilized in your review that supports your defense.

All appeals should be sent in timely. Unlike the commercial insurance carriers who will enter into a dialogue with you after the submission of your appeal, Medicare does not provide the luxury of waiting to discuss your appeal. Its an all or nothing proposition.

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MSSNY PAC

(Continued from page 1)

• Formally permitted non-physicians to perform laser hair removal with virtually no physician oversight.

Moreover, working with many other public health groups, we scored an important public health victory by assuring that e-cigarettes are regulated similar to other tobacco products.

However, as you will note below, we are very disappointed that the Legislature chose to pass a one-sided liability expansion bill at a time when physicians and hospitals already face exorbitant liability costs, and potentially significant cuts from Washington. With Governor Cuomo waging on aggressive public campaign to warn the public about the threat to our health care system and New Yorkers generally if cuts arising from various proposals to repeal the ACA are enacted, please let him know that further increases in liability costs would make these health care access problems even worse.

We thank the many of you who responded to our call throughout the Session to contact your legislators when requested.

Sincerely,
Your MSSNY Division of Government Affairs Team

ALLIANCE

SAVE THE DATE: AMSSNY FALL CONFERENCE

The Alliance will hold its annual Fall Conference on October 15-16 at the Double Tree Inn in Schenectady. It promises to be an exciting gathering, featuring speakers on such topics as long-term care and estate planning, and brain trauma and rehabilitation.

Helen Hines from the Traumatic Brain Injury Grant Program at the New York State Department of Health, along with two of our very active members—who have experienced first-hand the devastating effects of concussions on their daughters—will address the audience.

Make your reservations by calling the Double Tree Inn at 518-393-4141. The hotel is located at 100 Nott Terrace, Schenectady, NY 12308. Additional details will be available soon. Please mark your calendars. In the meantime, please contact Kathy Rohrer, Alliance Executive Director, if you have any questions. She can be reached at 1-516-488-6100 x396 or by e-mail at krohrer@mssny.org.

OBITUARIES

CAMPBELL, Emmett E.; Silver Spring MD. Died May 11, 2017, age 89. Nassau County Medical Society.


DEUTSCH, Frederic Herbert; Tenafly NJ. Died February 02, 2017, age 90. New York County Medical Society.

DWARKA, Regev R.; New City NY. Died April 18, 2017, age 78. Bronx County Medical Society.

GOTHGEN, Svend; Buffalo NY. Died April 29, 2017, age 73. Erie County Medical Society.

LAZAR, Louis; Buffalo NY. Died April 28, 2017, age 98. Erie County Medical Society.

MAGAGNINI, Antonio; Brooklyn NY. Died March 16, 2017, age 87. Medical Society County of Kings.


RASKIN, Raymond Adrian; New York NY. Died April 08, 2017, age 95. New York County Medical Society.

ROBBINS, William Clinton; Mount Dora FL. Died May 17, 2017, age 95. New York County Medical Society.

TROUTMAN, Richard Charles; Bal Harbour FL. Died April 14, 2017, age 94. New York County Medical Society.

WEISSMAN, Gary Steven; New Hyde Park NY. Died May 04, 2017, age 65. Nassau County Medical Society.


YURCHAK, Anthony Michael; Orchard Park NY. Died May 10, 2017, age 81. Erie County Medical Society.

ZAROU, Donald Michael; Brooklyn NY. Died May 20, 2017, age 82. Medical Society County of Kings.

ZWANGER, Jerome; Massapequa NY. Died April 29, 2017, age 93. Nassau County Medical Society.
appeal, Medicare requires you to go through two levels of appeals before you get to voice your opinion, which is done at an Administrative Law Judge (ALJ) hearing.

**COMMERCIAL CARRIERS**

First let’s look at the commercial carriers. The commercial carrier will reply to your appeal and in many cases, reduce the overpayment demand. At this point you can call the carrier and either enter into negotiations regarding a repayment or request to speak with their auditors if you still feel strongly they have not credited you appropriately. In either case you have the opportunity to present your case and enter into a negotiated amount.

**REDETERMINATION**

Medicare’s first response to your appeal is called a “redetermination.” This usually comes back completely unfavorable as you are asking the same folks who reviewed your claims the first time to admit they made a mistake and overturn their determination. This very seldom happens.

So now you have the opportunity to resubmit your appeal to a Qualified Independent Contractor (QIC). This is a new and independent review by auditors who did not take part in the first review. Remember when resubmitting your appeal this is the last opportunity you have to submit any additional supporting documentation. The next level of appeal will be at the ALJ level and documentation not submitted with the second appeal may not be accepted at the ALJ level.

The determination by the QIC is called a “Reconsideration.” This will usually come back partially favorable. You want to carefully review the determination as usually more than one reviewer works on the case. When you have multiple reviewers on the same case you can end up with conflicting line items.

For example, one reviewer may allow a line item while another who reviewed similar documentation for a different patient may deny it, even though both claims were documented with similar supporting documentation.

Based upon your review of the reconsideration, you are now faced with a decision. Do you take it to the next level (ALJ hearing) or submit the overpayment demand? In most cases this comes down to finance.

If the overpayment demand is well into the hundreds of thousands or millions of dollars, it is well worth the cost of hiring and attorney, a coder and, if applicable, a statistician to assist with the extrapolation. It is important to keep in mind it can take approximately two years to get to an ALJ hearing at which time the amount owed to Medicare is accruing interest at a high rate. Additionally, the carrier may begin to offset the amount from your current claims.

If the refund amount is relatively small it simply may not be cost effective to pursue the appeal process any further.

Medicare also has an additional two levels of appeals after the ALJ level. To learn more about the Medicare appeal process, download Medicare Parts A & B Appeals Process.

Remember the key to a successful appeal is to respond comprehensively at the first request for records, utilize nationally recognized source documents, prepare the appeal by utilizing the carriers excel spreadsheet and adding in your findings, highlighting key parts of the documentation and writing a clear concise narrative.

The easier you make it for the auditor the greater your chance for a favorable outcome.

**Jacqueline Thelian CPC, CPC-I, CHCA** - is a highly respected and nationally recognized Healthcare Consultant, Certified Professional Coder, Auditor, ICD-10 Trainer, subject matter expert, author and sought after speaker and educator with nearly three decades of experience in medical coding and practice management. Ms. Thelian has been involved with medical billing, reimbursement and documentation issues and has taught extensively for academic medical centers, hospitals, private physician practices and various healthcare organizations. For more information, please call Medco Consultants, Inc. at (718) 217-3802 or email info@medcoconsultants.com.

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**MSSNY Members Only: Unpaid Claims We Can Help!**

In 2016, MSSNY’s Ombudsman Program was successful in recovering $89,815.79 for physicians who had reached a stalemate regarding unpaid claims. From January to June of 2017, the program recovered $121,441.68 for our members who availed them of the Ombudsman service.

If you are a member in good standing, this service is available to you for FREE!

For further information, call 516-488-6100 ext 334 or 332.
More New York Residents Have Access to Prescription Savings

Statewide Prescription Assistance Program Offers a Prescription to High Healthcare Costs

The Centers for Disease Control reports that Americans spend more on prescription drugs than people in any other country: some $45 billion in out-of-pocket dollars in the last year alone. With that in mind, the New York Rx Card is reminding physicians that their patients who aren’t insured or who take prescription drugs that aren’t covered by their health insurance plans, can use the New York Rx Card to obtain discounts of up to 75 percent off the retail price for FDA-approved medications.

New York Rx Card has been working closely with Medical Society of the State of New York, as well as numerous clinics and hospitals around the state to distribute free discount prescription cards so that all New York residents will have access to this free program. New York Rx Card was launched to help the uninsured and underinsured residents afford their prescription medications. The program can also be used by people that have health insurance coverage with no prescription benefits, which is common in many health savings accounts (HSA) and high deductible health plans.

Another unique component of the program is their preferred pharmacy option. New York Rx Card has chosen CVS as their preferred pharmacy so that residents who don’t have access to a computer and can’t obtain a hard card, can visit any CVS to have their prescriptions processed through New York Rx Card. Residents can simply reference “New York Rx Card” to have their prescription processed through the program. New York Rx Card is accepted at over 68,000 participating regional and national pharmacies.

New York Rx Card has helped residents save over $143 million since its inception in 2010. You can help by encouraging your patients to print a free New York Rx Card at www.newyorkrxcard.com. New York Rx Card is also available as an app for iPhone and Android. You can search “Free Rx iCard” in the app store. Any physicians who are interested in ordering free cards for their clinic/hospital can email Chez Ciccone, New York Rx Card Program Director at fciccone@nyrxcard.com.

For more information or to order free hard cards visit: www.newyorkrxcard.com
Chez Ciccone • fciccone@nyrxcard.com
Phone: 800-931-2297

New York Rx Card Preferred Pharmacy:

CVS/pharmacy
Physician Burnout as an Individual and Public Health Issue

(Continued from page 7)

tive care planning, as well as the emotional availability to the patient and family.

Cognitive processing capacity of the human mind is limited by the cognitive load put on these capacities. Intrinsic vs. extraneous vs. germane cognitive load are the factors involved in best decision making. Intrinsic load refers to the inherent difficulty of the mental task. Extraneous load refers to a burden of unnecessary information that uses up cognitive processing. Germane load refers to an organized pattern of thought that helps in efficient learning and mental tasks.

Excessive extraneous cognitive load will deplete EF away from the ability to make good medical decisions (see reference 11 for multiple supporting references).

OUR CURRENT HEALTH ECOSYSTEM

Figure 1 displays the current health care system ecosystems of interacting factors.

- Macro level describes national state industry and regulatory factors.
- Meso level is at the hospital or healthcare system factors.
- Micro level describes individual clinicians with other staff and with patients and their families.
- Exo level describes the individual physician and their family in daily life outside of medicine.

The individual physician is surrounded by an environment that promotes the medical culture of endurance and self-effacement such that how you feel does not matter, and you have to remain professional at all times (as opposed to acknowledging your feelings but choosing your behaviors). Internally, there is a sense of altruism, workaholism, perfectionism, and obedience to authority. There is also the well-known fact that everyone is evaluating their competence around them and they don’t want to be seen as ‘weak’ with so much at stake: all the personal sacrifice, debt, and a family that is depending upon them.

Some factors are well intended for patient care but are not coordinated, harmonized, but these mechanisms are paradoxically making patient care less safe. With the rapid roll out of healthcare reform, and many non-clinicians involved in making the decisions, a ‘halo bias’ led to the adoption of too many measures that are attempting to quantify quality. Just because someone calls it “quality” it must be good (since the word ‘quality’ has a halo over it). The tsunami of these measures slipped by sufficient scientific scrutiny. Too numerous chaotic and unproven quality metrics are not good and in fact harmful (12).

Some factors are not well intended, and are actually devised to wear down the physician as a means of cost control, by hassle factors that physicians experience while trying to

Continued on page 17)
Physician Burnout as an Individual and Public Health Issue

(Continued from page 16)

achieve care for their patients. There really is no justifiable room for the continuance of these wear-down methods by the healthcare business industry given the seriousness consequences of burnout.

Table 2 outlines a number of strategies to be considered to reduce burnout in physicians. The combination of individual and organizational interventions is required to be effective and sustainable (13, 14).

CONCLUSIONS
1. Burnout can no longer be ignored among physicians as it can take a toll on both the physicians and their patients.
2. Attention to the fourth aim (experience of providing care) of the Quadruple Aim framework is critical to the success of the other 3 aims of cost quality and patient experience.
3. There are complex factors that can contribute to burnout and its impact is very costly.
4. “Meaningful progress will require collaborative efforts by national bodies healthcare organizations, leaders, and individual physicians as each is responsible for factors that contribute to the problem and must own their part of the solution” (15).

In the next article, we will review how you can measure burnout, and what the current state of the State is in terms of burnout, its causes, and its consequences. We will also address how we can cope with it, as well as strategies for organizational intervention based on literature and the results of the recent MSSNY survey.

RECOMMENDED READING:
- Shanafelt TD, Noseworthy J. Executive Leadership and Physician Well-being:
- To Our Fellow Health Care CEOs Health Affairs Blog March 28, 2017

Table 2

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>ORGANIZATIONAL</th>
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<tr>
<td>- Encourage recognition of Burnout in the face of Medical Culture and Hidden Curriculum</td>
<td>- Overcome the medical culture of endurance where staff must deny stress</td>
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<tr>
<td>- Physicians start off more resilient than general population: Individual interventions must be paired with organizational interventions</td>
<td>- Leadership style and concern is key</td>
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<td>- Wellness Seminar series as “safe place’</td>
<td>- Establish: Wellness Initiative Strategic Planning Work Group</td>
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<td>- Avoid blaming the victim</td>
<td>- Include human factor issues in healthcare delivery</td>
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<tr>
<td>- Normalize self care</td>
<td>- Neuro-cognitive and organizational ergonomics</td>
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<td>- Normalize boundaries between work and home despite technology</td>
<td>- The Quadruple Aim Framework:</td>
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<tr>
<td>- Multiple individual interventions available</td>
<td>- Costs, Quality, Patient experience, and Fourth Aim: Experience of providing care</td>
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<tr>
<td>- Mindfulness</td>
<td>- Attempt to understand the front line problems:</td>
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<td>- Resiliency training</td>
<td>- Anonymous survey to learn key pain points for clinicians, round table discussion of aggregate findings and leadership commitment to action</td>
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<td>- Gratefulness</td>
<td>- Encourage stronger administrator/physician partnerships</td>
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<tr>
<td>- 3 Good Things</td>
<td>- Use clinician wellness and career satisfaction metrics and tie these into quality of care, reduction of malpractice, errors, and patient satisfaction</td>
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<tr>
<td>- Yoga</td>
<td>- Block out time and resources to help organize completion of all mandatory, regulations</td>
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<tr>
<td>- Coaching</td>
<td>- No reporting of seeking mental health care on licensure, malpractice carrier, credentialing applications or renewals</td>
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<tr>
<td>- Employee Assistance-Wellness Division</td>
<td>- Confidentiality in seeking help</td>
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<td>- Self Help websites and literature</td>
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<td>- Peer Support</td>
<td></td>
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<tr>
<td>- Clinician ombudsman to have work/life balance representation</td>
<td></td>
</tr>
<tr>
<td>- Diet, exercise</td>
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</table>

REFERENCES
2. Shanafelt TD, Hasan O, Dyrbye LN, Sinsky C, Satele D, Sloan JA, Dyrbye LN. Distress among matriculating physicians is no justifiable room for the continuance of these wear-down methods by the healthcare business industry given the seriousness consequences of burnout. Proc. 2015 Dec;72(12):1192-8.
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In addition, St. Francis offers excellent Thoracic, Vascular, Oncologic, Neurosurgical, and Orthopedic Surgical Programs. We have a very active Emergency Department. The hospital offers the latest in technologies such as Therapeutic Temperature Modification, Impella, ECMO and LVAD. Our expert and experienced medical staff supports strong medical and surgical subspecialty programs.

Aside from Certified Critical Care Nurses, many who have more than 20 years of experience and are expert at caring for this complex patient population, we have a growing pool of Intensivist mid-level practitioners who work hand in hand with our Intensivist physicians to coordinate the care of the critically ill patient, minister to them and perform procedures.

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