PRESIDENT'S CORNER

The Changing Health-care Landscape

Background

I work as division chief in an academic practice based at a 650-bed community hospital that serves as a major teaching facility in Brooklyn, New York. As full-time, salaried pulmonary, critical care, and sleep medicine attending physicians, my associates and I interact with our private practice colleagues on a daily basis. These interactions provide me a unique perspective about the concerns that both private practice and academic physicians harbor about the changing health-care landscape.

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The Problem

Health-care reform has introduced a sense of insecurity and "fear of the unknown" in the minds of our ACCP members, especially those in private practice. These insecurities and fears complement our natural human tendency to resist change. However, regulatory agencies and payers are directing both physicians and hospitals alike to utilize outcomes-based performance improvement metrics, regularly report their performance and outcomes data, and, in instances, accept variations of an evolving, pay-for-performance reimbursement system that represents a culture of, and impetus for, change.

Most physicians agree that rising health-care costs need to be reigned in. The current iteration of health-care reform, however, makes the model of independent private practice extremely difficult to sustain. While academic practices will also be affected, the increased tracking of defined performance improvement measures, complications, and hospital-acquired events; the escalating potential liability under both the fraud and abuse statutes and various auditing contractors; and dwindling reimbursements are likely to affect clinical practitioners disproportionately. Even more so, the rising costs of routine clinical practice, added to the expenses of both investment in electronic health record implementation in their offices and electronic integration with the hospitals where they practice, disfavor private practice physician groups. Finally, private practice physicians face heightened competition from contracted groups for hospitalist, intensivist, and telemedicine (remote monitoring) services, as well as for diagnostic testing services.

Health-care Reforms

What are the major tenets of the Obama health-care reforms? These include seven major components:

- *Universal coverage*: Health-care insurance should be universal, ie, it should extend to include the estimated 50 million currently uninsured individuals. Dependent children can already stay on their parents' insurance until the age of 26 years, as a result of the health reform bill. Individuals or families will be mandated to select and purchase insurance by 2014, even if they are young and in good health. Subsidies to purchase insurance will be available to low income families.
- *Portability and limited coverage exclusions*: Health insurance coverage should be portable—people should not lose insurance if they change jobs. Additionally, individuals with preexisting conditions should not be entirely denied or offered only limited health care.
- *Affordable*: Health-care premiums should be affordable. This will require reductions in escalating administrative costs, unnecessary testing, unproven modes of treatment, and other inefficiencies in the health-care delivery system. The revamped system should protect families from bankruptcy in the event of a catastrophic illness.
- *Choice*: Individuals will have a choice of the hospital, clinic, doctor, and health services in their community. They will be able to retain their employer-based health plan if they so chose.
- *Quality:* The health-care delivery system should provide standardized care, predicated upon evidence-based principles, improving patient safety, and reducing variability from doctor to doctor or institution to institution. Such standardized, less variable care remains consonant with the principles of patient-centered, family-focused care. The use of electronic medical records and health information technology to develop patient databanks, track outcomes, identify complications, and measure effectiveness of medical interventions will be provided incentives and will catalyze such care.
- *Preventive medicine:* Promote public health measures to improve wellness and prevent disease. Included in this category are vaccinations, tobacco education, smoking cessation programs, prevention of obesity, and others.
- *Sustainability:* The system should be self-sustaining with appropriate cost-sharing between individuals, employers, and public sources. Reform will center around insurance issues and much less on reimbursement issues.

Physician Perceptions About Health-care Reforms

General

In a survey carried out by Merritt Hawkins, on behalf of The Physicians Foundation, approximately 2,400 physicians responded with their perceptions about health-care reform. The main survey findings were as follows:

- The majority of physicians opposed the passage of health-care reform.
- Most physicians anticipated caring for a greater number of patients and, simultaneously, they felt less financially stable in their practices.
- More than half of the physician respondents planned to change their practices in a manner to limit access to new patients and to explore options of retirement or working part-time.
- The model of a full-time, independent physician engaged in private clinical practice is likely to be replaced by part-time, locum tenens and concierge practitioners.

ACCP Membership Perspectives

What do our members think of these health-care reforms? The following provides a sample of some membership views on this tough issue.

- Dr. Anthony Saleh, FCCP, a well established private practice colleague in pulmonary and critical care medicine at NY Methodist Hospital, where I lead our academic pulmonary practice, had the following comments to make: *"As a busy practitioner, I have to maximize my time management. The ACCP can play a pivotal role in keeping me informed of the changes coming down the pike. With all of its emphasis on education, the College can help streamline my efforts toward continuing my busy practice and allowing me to keep abreast of all of the newest innovations in pulmonary and critical care medicine. I also hope the College will be able to help me deal with the increased scrutiny that practitioners will be facing over the next 5 to 10 years."*
- Dr. Douglas J. Cohen, FCCP, a practicing pulmonologist at Pulmonary and Sleep Physicians of South Jersey, had this to say: *"I am a private practitioner for 30 years. It is an impossible environment to practice in and make a living. Payments for work are dropping (loss of consult code, decreased insurance payments), and hospitals are competing for pulmonary talent to cover the ICUs. Private practitioners cannot compete with hospitals for salary. We cannot recruit new physicians. Isn't anyone listening?"*
- Dr. Tom Russi, who runs a busy solo pulmonary and critical care medicine practice in Bayshore, Brooklyn, New York, when asked about his perceptions of how health-care reform will affect his private practice remarked: *"As a physician who is accustomed to following a mental process when confronted with a decision or problem, I find it frustrating more often than not when asked to make*

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March Is DVT Awareness Month

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a general, blanket statement about health-care reform, especially as it relates to the state of private practice. The usual process of evaluating data, filtering out relevant from irrelevant information, and generating a risk/benefit analysis seems to inevitably lead my brain to an uncomfortable mental hardwiring freeze. I believe this neuronal paralysis stems from the overwhelming amount of data and variables out there that have not yet been organized and packaged properly for practicing physicians to fully digest. In other words, I feel uncomfortable giving a prognosis when I am still uncertain of the diagnosis."

Hence, in order to stay afloat and remain engaged in delivering clinical care, many physicians I spoke with thought they will have to increase their patient load, sell their practices and join large financially solvent hospitals, start working part-time, or evolve to offer boutique medical services.

Analysis of the Problem

The changes proposed as part of health-care reform are not trivial and have far-reaching consequences. In analyzing the impact of these changes for our members, the following issues come to mind:

▶ *Excessive information to digest*: The health-care reform bill is 1,000 pages of fine print. Our physicians, already inundated with clinical responsibilities, do not have the time to read through this maze of legal terminology and prepare their practices for the imminent changes. Furthermore, this bill will engender many thousands of additional pages of regulations to achieve implementation.

▶ *Success of reform will depend upon physicians' participation and leadership*: Most experts agree that curbing spiraling costs is, to a great measure, in the hands of the medical profession. This is because doctors, generally engaging in shared decision making with their patients, determine the selection and timing of different medical resources. Paradoxically, at a time when physicians feel they are losing control, they should feel empowered!

▶ *Perceived conflict of interest under a fee-for-service structure*: A perception in the minds of many legislators and policy makers is that most doctors are paid on a fee-for-service basis. This payment methodology may lead physicians (especially specialists) to order tests, perform procedures, and suggest treatments that drive up costs, despite guidelines and evidence to the contrary. In fact, research has shown that even when clinical guidelines are available, they may not be applicable to a particular patient or not appropriate for complex patients with comorbidities. Consequently, guidelines may not be adhered to for a variety of patient and process characteristics rather than the failure of physicians to act responsibly. Furthermore, global payment methodologies associated with risk bearing may confront many of the problematic results and adverse consequences associated with full risk capitation in the past. Notably, practice patterns vary significantly across geographically disparate regions of the country and between different physician specialties caring for the same patients and problems; yet, at present, these variations are the subject of intense scrutiny and remain without full explanation. In addition, many hospitalizations are unnecessary and many errors preventable, although systematic, generalizable, scalable models to reduce such unnecessary hospitalizations and abolish medical errors remain in their infancy. Outcomes research institutes have been set up to conduct comparative effectiveness research to begin identifying which, among potentially many, seemingly effective therapies are actually the most effective or have the safest profile. Recently, the American College of Physicians has recommended physicians "practice effective and efficient health care and to use health-care resources responsibly." They coined the term, "parsimonious care," which urges physicians to utilize resources "wisely" in an attempt to ensure that "resources are equitably available." Regulating resource utilization may be possible through Accountable Care Organizations (ACOs). These ACOs are physician and hospital networks that share responsibility for providing care to patients, with opportunity for novel and blended payment models to avert the potential distortions created by either pure fee-for-service or full risk capitation environments. By integrating systems, rewarding favorable outcomes, and coordinating care of a large number of patients, ACOs may act as a model for "parsimonious care."

▶ *Greater scrutiny of physicians*: In an effort to enforce utilization of best practices, minimize variations in quality of care, improve outcomes, reduce costs incurred from unproven treatments, and lower complications, physicians will be under greater scrutiny by patients, regulatory agencies, and insurance companies. Physicians will be required to utilize electronic medical records; perform practice improvement modules (perhaps outside the auspices of the board certification process); initiate, if not demonstrate, and complete quality improvement projects; practice evidence-based medicine; and be subject to the incentives and disincentives of value-based purchasing. Physicians' complications and outcomes will be tracked and patients encouraged toward high "value" physicians (with lower cost, lower complications, better outcomes) by tiered copayments and other financial incentives.

▶ *Lack of commensurate limitations upon consumers' choices to treatments*: A critical missing link in this equation (to drive health-care costs down) is the absence of public commentary and engagement of our patients in the discussion of the impact of the consequences of health-care reform upon their treatment choices. Our society has not been educated about the possible specific restrictions imposed to limit access to, and choices in, medical diagnostic testing and potential therapeutic treatments. The comparative effectiveness findings from the Outcomes Research Institutes cannot be used to limit diagnostic tests and medical treatments from physicians if patients nonetheless demand such care. The concept that sometimes "less is more," in medical care has not been adequately conveyed to, or enforced with, our patients ("the consumers").

Moving Forward

The College, poignantly aware of its responsibility toward the members, has taken multiple steps in this era of health-care reform:

1. Setting up an infrastructure utilizing the Practice Management Committee, Chest Medicine Affairs Committee, the ACCP Governors, and staff who will work to provide education to the College on regulatory issues.
2. Expansion of AQuIRE-the College-maintained secure clinical database for its members. This database is developed by physicians, for physicians, and is more trusted by providers than clinical and administrative databases kept by regulatory agencies or insurance companies. Participating physicians are provided access to a secure, Web-based registry where they can easily enter the procedures they perform, the complications they encounter, and the practice improvement measures they utilize in their day-to-day work. These registries are associated with online educational activities that are targeted to the outcomes being assessed. The combination of these targeted educational activities and registries for practice assessment, called performance improvement modules (PIMs), are approved for awarding participants American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) part IV credit. Such resources have special utility for College members' recertification, licensure, and liability insurance.
3. Promoting the training of our physicians and other members in acquiring new skill sets, such as ultrasound, management of the difficult airway, performance of percutaneous tracheostomy, or advanced modes of mechanical ventilation through simulation courses offered throughout the year (www.chestnet.org/accp/education).
4. Planning dissemination of more information about health-care reform. Over the next 7 months, a series of articles entitled, "Health-care Reform: Is Anyone Listening?" will be published in *CHEST Physician*. The schedule of planned articles includes the following:

March: Inaugural article to introduce and explain the purpose of this series (this article).
April: Legislative and regulatory changes in health care
May: Apprehension about change, remodeling, and surviving in private practice.
June: The impact upon pulmonary, critical care, and sleep medicine of legislative and regulatory changes in the day-to-day practice of medicine (including ICD-10, adoption of electronic medical records, practice improvement modules, quality improvement, evidence-based medicine, value-based purchasing, and more.
July: The top 10 things a practitioner should do to prepare for impending change.
August: As health-care reform proceeds, what are the forthcoming, expected changes in the practice of sleep, critical care, and pulmonary medicine?
September: What are the available ACCP resources to help members prepare for the expected changes in health-care delivery?

Each article will present the relevant discussion in a concise and easily assimilated manner.

We will continue to monitor the changing health-care landscape and provide timely and useful information and suggestions to our members, so they can adapt and react appropriately and effectively. Change in health care is inevitable; let us work together to be as knowledgeable and well-equipped as possible to meet the challenges that confront us. ■

This Month in *CHEST*: Editor's Picks

BY DR. RICHARD S. IRWIN, MASTER FCCP
Editor in Chief

▶ Refractory Asthma: Importance of Bronchoscopy to Identify Phenotypes and Direct Therapy. *By Dr. J. T. Good Jr et al.*

▶ Medication Chart Intervention Improves Inpatient Thromboembolism Prophylaxis. *By Dr. D. S. H. Liu et al.*

▶ Surveillance Tracheal Aspirate Cultures Do Not Reliably Predict Bacteria Cultured at the Time of an Acute Respiratory Infection in Children With Tracheostomy Tubes. *By Dr. J. M. Cline et al.*

▶ Obstructive Sleep Apnea: Effects of Continuous Positive Airway Pressure on Cardiac Remodeling as Assessed by Cardiac Biomarkers, Echocardiography, and Cardiac MRI. *By Dr. J. Colish et al.*

▶ Functional and Muscular Effects of Neuromuscular Electrical Stimulation in Patients With Severe COPD: A Randomized Clinical Trial. *By Dr. I Vivodtzev et al.*

▶ A Randomized Trial to Improve Communication About End-of-Life Care Among Patients With COPD. *By Dr. D. H. Au et al.*