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Health Reform and the Future of Medical Practice

Randy Wexler, MD, MPH

The only thing that is certain in medicine is that nothing is certain in medicine. Although health care has changed in many ways over the years, nothing will have a greater impact on how care is delivered than the Patient Protection and Affordable Care Act of 2010 (ACA). Many physicians are angry at passage of the ACA, and lobby for it to be repealed, but there are reasons that this law was passed by Congress. The lack of health coverage for tens of millions of Americans, poor care coordination, absence of patient-centeredness, focus on the quantity of services delivered as opposed to the quality of patient outcomes, and high cost that does not necessarily translate into improved patient health all set the stage for passage of this law. Most physicians are familiar with the aspects of the ACA that increase coverage through creation of health insurance exchanges and expansion of the Medicaid program. Fewer are aware of how changes to reimbursement will revolutionize the way they practice.

Although health care policy may at times appear as though it is being made in a vacuum, that is not the case. To evaluate the incentive-based reimbursement mechanisms that are now being promoted by the ACA, the Centers for Medicare and Medicaid Services (CMS) conducted the Physician Group Practice (PGP) demonstration project starting in 2005 [1]. A diverse group of 10 health systems, with varying structures and physician cultures, participated [2]. When the results were published in the spring of 2009, the 10 groups had reported meeting 29 of the 32 established goals [1]. Half of the health systems together saved Medicare a total of $38.7 million, earning an incentive-based payment of $31.7 million [1]. More than half of this went to the Marshfield Clinic in Wisconsin, a health system comprising 775 physicians in more than 80 medical specialties and subspecialties located in 54 sites throughout Wisconsin [3]. Based in part on the demonstrated success of coordinated care in this pilot project, the ACA made coordinated care a centerpiece of health reform, calling for the establishment of accountable care organizations (ACOs).

Accountable Care Organizations and Episode-Based Payment

An ACO is a health care delivery structure comprising various primary and specialty care physicians, hospitals, ancillary providers, subacute nursing facilities, and others that together are held accountable for the cost and quality of the care they deliver [1]. To succeed, an ACO must: (1) manage patients across all types of care including inpatient, outpatient, and ancillary; (2) prospectively plan budgets and resource needs; and (3) provide valid and reliable performance data [4]. To encourage

providers to adopt the methods necessary to make such changes, the CMS will likely move from fee for service to other forms of reimbursement.

Most physicians are familiar with payment under Medicare's diagnosis-related-group (DRG) mechanism. In this form of *bundled payment*, Medicare reimburses a fixed amount for all care delivered to a patient during an inpatient admission. In the near future we are likely to see a transition to *episode-based payment*—payment for all services, including physician, hospital, and ancillary care, provided to a patient during an *episode of care*. In this model, an episode may extend from the inpatient period to days or weeks after discharge. This lengthening of the time period payments cover, from an admission to an "episode," is likely to eventually extend even further, to global capitation, which entails fixed payments shared among all caregivers for the total care a patient may need in a given time period, based on actuarially determined rates.

When this transition occurs, physicians will need to negotiate for their "piece of the pie." They will have to learn to relinquish some of the autonomy they have historically enjoyed because they must now care for patients in teams in which there is more than one captain. Culture change will be the single biggest barrier for physicians to overcome, regardless of how health care changes.

Changes to the Culture of Medicine

To survive in this new environment, it will be incumbent on physicians to adopt new ways of thinking and strategies that are integrated, comprehensive, and coordinated.

Coordination of care and timely transmission of information. Poor care coordination in our current health system contributes to suboptimal outcomes, not to mention increased cost. Factors that contribute to this problem include poor communication, wrongly completed forms, the lack of relationships between physicians and other health care workers, and the use of informal support mechanisms such as curbside consults [5, 6]. Between 1995 and 2006, communication breakdown was the leading cause of sentinel events reported to the Joint Commission on Accreditation of Hospitals [5], and assessment of the level of communication between hospital physicians (HPs) and primary care physicians (PCPs) reveals significant cause for concern. Bell and colleagues evaluated the frequency of communication between the two groups regarding patients hospitalized for various medical problems [7]. Only 77 percent of PCPs were aware their patients had been hospitalized. HPs and PCPs communicated about the hospitalized patient only 23 percent of the time, and a discharge summary was available within 2 weeks in only 42 percent of admissions.

Poor care coordination is due in part to physicians' practicing in semi-isolation—caring for patients within their offices or chosen institutions, and often focused on a narrow disease set or specific medical problem. In the future, physicians will need to adopt mechanisms for communicating clinical information in a timely fashion, as well as being more comprehensive in their approach to patient care. It will not suffice for physicians to send discharge summaries to other physicians a week later

or tell patients to call other doctors when they are too busy to see them. Such practices impact outcomes negatively, and in the future they will affect reimbursement negatively. Furthermore, physicians will be responsible for a patient's care not only within their office or health system but also when their patients are cared for in other systems. This will require a fundamental change in culture. Physicians will need to establish new, trusting relationships outside their usual comfort zones. They will need to communicate, collaborate, make themselves accessible, and work in shifting teams in ways they never have before.

To support needed change and promote the timely transmission of data both within and between physician offices, health systems, hospitals, and other care providers, a robust health information technology (HIT) infrastructure will become necessary.

Greater focus on preventive care. HIT will also transform how physicians care for patients by making the practice of medicine proactive (prevention-based) rather than reactive (based on disease acuity). Health care today is typically reactive in nature. Patients get treated when they have flareups, acute episodes, or bothersome symptoms—exacerbations of asthma, myocardial infarction, discomfort, and so on. Though such care will still be necessary, a transition to a more proactive practice method will occur in the future. Patients will certainly continue to experience chronic disease, but, given that upcoming reimbursement models will probably emphasize quality of outcomes over quantity of interventions, the focus will be more on preventing that disease or its sequelae in the first place.

HIT will be an important part of those efforts. In most offices today a patient with diabetes, for example, is seen every 3 to 6 months, depending on disease state and comorbidities. It is the responsibility *of the patient* to return for care. In the future it will be the responsibility *of the physician* to ensure the care is delivered. When reimbursement is likely to be increasingly tied to quality of outcome rather than quantity of care, it will be incumbent on physicians to ensure that patients (in this case, those with diabetes) receive recommended care whether they take the initiative to come to the office or not. This will require leveraging HIT to develop solutions, such as disease registries that track desired parameters such as A1C and LDL levels, blood pressure, and monofilament exams. When numbers are outside the desired range or such services are due to occur, automatic reports can be sent to physicians so that patients can be contacted *proactively* and the needed care provided. HIT also provides the means to track other needs and populate orders or send reminders to physicians at the time of an unrelated visit: a patient may be coming in for diabetes monitoring, but does he or she need a pneumonia vaccine, flu vaccine, a colonoscopy, or other preventive service? Such clinical management support would help to bridge the gap between what is currently being done and what needs to be done.

Improved access to care. The *how* of medical care will certainly change in the future, but so will the *when*. Significant numbers of patients currently seek care in emergency departments (EDs), urgent care facilities, or retail clinics because they

cannot see a physician at a time that works for *them*. If physicians are reimbursed by service, they are not penalized when this occurs. When reimbursement is tied to episodes of care, quality markers, and financial targets, the use of the ED for nonurgent care will not be practical. The Center for Studying Health System Change found that only 47.3 percent of patient visits to the ED were classified as either urgent or emergent [8]. The need to improve access to care and reduce cost will require physicians to rethink their work day, the hours during which they are available, and other kinds of access for patients such as e-mail or web portals.

Conclusion: ACOs Are Coming

It is my belief that we are headed towards a health system that reimburses based on global capitation. Such a change allows the government and others to better estimate expenditures and places responsibility (risk) for cost on providers; the primary incentives in the new system will be the reduction of care determined to be unnecessary on a population level and, hence, of overall costs. The institution of ACOs (or whatever the mechanism becomes) is the start of such a direction. Episode-based care *is* the first step toward global capitation, to an even greater degree than physicians have seen before. Should that occur, physicians who have not laid the groundwork for such change will find themselves in a precarious financial position. In a global-capitation world, physicians will need the lessons learned from their ACO experience to succeed.

Many will say that they have heard such predictions before and nothing ever happened. They believe the same will occur will this time. I believe they are wrong. The percent of GDP devoted to health care continues to rise. Baby boomers are starting to retire. We are in the middle of the worst economy since the Great Depression. The can has been kicked down the road for decades, but we have run out of road. Physicians will not be able to ignore the seismic changes in health care that are occurring all around them. The first ACO is scheduled to go live January 1, 2012.

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Randy Wexler, MD, MPH, is an associate professor of family medicine at The Ohio State University in Columbus. He received his MD from Wright State University and his MPH from The Ohio State University. His research interests include improved blood-pressure control and health system change.

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