ALSO INSIDE:
In Sickness and in Health: Physicians as Captains of the Ship
Maryland DHMH Secretary
Joshua Sharfstein, M.D.
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Scan the code with your smart phone and download Maryland Medicine to your mobile device.
Are ACOs the Magic Bullet?

Harbhajan S. (Harry) Ajrawat, M.D.

It is not news to any physician that the delivery of health care and its associated costs are at the top of the national agenda. Starting with the passage of the Patient Protection and Affordable Care Act (PPACA) and continuing through the debate over the impact of the Medicare entitlements on the national debt, the delivery of medical services, and particularly the cost of that delivery, has been a major national focus.

Although physicians might prefer to focus on direct treatment of their patients and leave the policy debates to others, the physician has an invaluable perspective on this debate that, if brought to the table, can ensure that medical care continues to improve in quality and efficiency. At a time of crisis in health care delivery, it becomes an ethical imperative for physicians to participate in the discussion.

Accountable care organization (ACO) is a new buzzword in the medical community that may go a long way towards meeting the above goals and create a model of care that is driven by physicians acting in the best interests of patients. The PPACA created a model for federal ACOs. The ACO model will provide financial incentives to health care organizations to deliver quality health care to Medicare beneficiaries in a cost effective way. This is another attempt to control rising health care costs while providing the best possible medical care. But will it work?

The ACO concept is an old one under a new name. In the 1990s, an at least superficially similar cost savings and quality model was tried through managed care organizations such as independent physician associations (IPAs), physician hospital organizations (PHOs) and healthcare maintenance organizations (HMOs). So what is different this time around?

The ACO model differs significantly in the following respects:

- It requires physician involvement in both leadership and care provision;
- It provides greater flexibility in the provider composition;
- It allows payment under a fee for service arrangement; and
- No health plan intermediary is required to contract with the provider organization.

The success of these organizations will depend on the trusting, respectful relationship among physicians who can work together in group practices that are totally integrated with a robust electronic health records (EHR) system. Cost savings can be realized through group purchasing power, more certain provision of preventive care services, coordination of employee benefits and consolidation of ancillary services. This in turn will translate into better care at reduced costs.

These benefits will only be possible if the Centers for Medicare and Medicaid Services and other federal regulatory agencies are willing to modify the anti-trust, physician self-referral, anti-kickback and other rules that currently restrict the ability of physicians and other health care providers to combine. The draft rules for ACOs that were issued by the Centers for Medicare & Medicaid Services (CMS) last spring and the safe harbor guidelines issued by the Federal Trade Commission and the Department of Justice at the same time provided some assurance that the federal government understood the obstacles that current law places in the way of the ACO. However, many physician advocacy groups such as the American Medical Association and MedChi, the Maryland State Medical Society, believe that the safe harbor protections did not go far enough and called for these to be strengthened. Additionally, these organizations called for the risk-sharing provisions of the ACO regulation to be modified so as to allow for more organizations to prudently participate.

If these regulatory hurdles are overcome, the ACO model may well become the best opportunity for physicians to become the real gatekeepers of the health care system, by controlling health care costs and providing high quality medical care, while receiving reasonable compensation. Although promising, the ACO concept has enormous challenges that will require continuing physician input. Physician leaders will need to acknowledge their responsibility to provide cost-effective, high-quality medical care and devote appropriate attention to design functional ACOs that will address the concerns of all health care providers, as well as patients, policymakers and third party payers. Once a workable model is agreed upon, physician leaders will need to articulate a compelling case for the ACO that enlists broad based physician support for implementation and convinces the public that physician-guided health care remains the best solution for America’s future.

MedChi has already assumed a leadership position in this debate. In June 2011, we submitted extensive comments on the draft regulations. Our Medical Policy Council has been entrusted with analyzing all new payment models and reporting back to membership. We will continue to take a leadership role and advocate for delivery models that will work to deliver quality health care efficiently. Please join us in this debate.
WEEKLY TO-DO LIST

Version 5010
Deadline:
JAN 1st, 2012

ICD-10 Deadline:
OCT 1st, 2013

Prepare Now for the Version 5010 and ICD-10 Transitions

The change to Version 5010 standards takes effect on January 1, 2012. The change to ICD-10 codes takes effect on October 1, 2013.

In preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards. Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013.

Make sure your claims continue to get paid. Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you’ll have what you need to be ready. A successful transition to Version 5010 and ICD-10 will be vital to transforming our nation’s health care system.

Visit www.cms.gov/ICD10 to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.
Whether private practice medicine survives or not, we physicians must have ownership of the final product. The Hobson’s choice of being run by the government or the insurers is just going to produce more and more misery and dissatisfaction with a profession that historically could boast of being the most satisfying of all the jobs in the world. The only people to benefit from this will be the dentists, who will increase by several fold their orders for bruxism guards and the drug stores which will eventually sell out of Tums®.

There is a fine line between being helped to assume leadership roles and being preached to. As is made clear in the article by Alice Gosfield, Esq., in this edition of Maryland Medicine, the systems which will emerge from the current medical melee will have at their heart...the physician, not the CEO or the CIO or the consultant. As Gosfield points out, these people will have their place in the organizational hierarchy, but the heart and soul of medicine can only be the person deemed by training and law to operate, admit, treat, advise and prescribe...the doctor of medicine. It will be increasingly important for the physician to participate in the ownership and leadership of the organizations that emerge from the current debate. It is vital, however, that those charged with and paid for aiding physicians to reach that goal understand that we don’t need lessons in “compassion, how to speak to patients, how to be a well-rounded doctor, and gain trust.” We do that, we know that, we are that, we have learned that and we embody that. There is no more of a turnoff to physicians than hearing that we need to learn such basics. And there is no bigger mistake made by those legislators, policy wonks and consultants who attach themselves to the mega-billion dollar health care dollar. Let me make it plain.

We are physicians...we are, for the most part, equipped before medical school with the savvy and temperament to enter the field. We are honed in medical school to a rather fine edge. We know what we are doing and we do it, generally, well. We deliver first-rate medical care. We make mistakes, but basically we are really good at what we do. Help us become leaders, but do not make the mistake of telling us how to be better doctors. Our own can teach us that...you cannot. Just help us in the area of owning the new medicine and integrating those skills that medical training and temperament don’t provide, and we will all benefit. Do otherwise, and we will not listen to you and there will be disarray.

As long as we’re speaking our mind, I feel we need to address both our state and national medical organizations, as well as my fellow physicians. This maelstrom in which we find ourselves pits very strong, very wealthy, very diverse, and very dedicat-ed people who want a stake in our system against working physicians, who have neither the time nor the energy to fight single-handedly. Yet because of the antitrust laws from which insurers are exempt, we must fight single-handedly. We have to take part with one arm tied behind our back unless those laws are changed. MedChi and the American Medical Association (AMA) are not subject to those restrictions in the main. MedChi can function, through subsidiaries, as a nucleus for physician groups and systems. MedChi knows how to advocate, and organize and you can bet its one and sole aim is the improvement of medicine for patients and physicians. We must...we MUST...get every colleague we know to join and pay their share, and then pay some more to insure that we communicate, legislate and advocate for our best interests and that of our patients. That means money and time spent. There is no alternative. It also means, MedChi, that this is our Rainy Day! The time for balanced budgets and husbanding all our assets is past...and we need to spend to insure that the physicians of Maryland and their patients are at the forefront of the new medicine. More effective communication among physicians, more troops in Annapolis, more advertising, and more national advocacy require more spending. This rainy day will turn into a deluge if we don’t.

**EDITORIAL STATEMENT**

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Let's Not Throw Out the Good with the Bad.

I would like to respond to Donald McDaniel and Dan D’Orazio’s column, “U.S. Health Care: In Need of an Industrial Revolution?” in Volume 12, Issue 2 of Maryland Medicine. I find several issues troublesome in this paper, which belies the author’s backgrounds as business managers.

I do not wish to minimize the safety crisis we currently have in our profession, but the number is constantly overstated. The oft-quoted 100,000 deaths (I presume this refers to the IOM report in the last decade; the reference was not cited in the paper,) was not a minimum number as the authors contend; it was a maximum. The minimum was far lower than that. If we are going to address the safety issue we need to get the right numbers.

Some of the solutions offered by the authors to decrease costs in our disjointed system are a little too narrowly focused. There is much reference to controlling how physicians are reimbursed, but while health care expenses have been growing by leaps and bounds physicians’ pay has been at best flat, and more commonly declining. How is cutting/changing our pay going to fix this? There is no mention in the paper about how the authors would tackle some of the real costs in medicine. Pharmaceuticals are tremendously expensive, yet when Medicare wrote the Part D portion they abdicated the ability to negotiate a better price for the pharmaceuticals, as Canada does. You only have to see me a couple times a year, but you have to take your antihypertensive every day. Our stop-gap for this has been to limit access to all but generic drugs, which has its merits, but we could go further. The article doesn’t mention liability reform. Every decision a physician makes is filtered through the prism of “what will this sound like in court?” This is certainly a way to cause us to deliver more expensive, but not necessarily better, health care. As for Dr. Shetty’s ability to deliver much less costly cardiac procedures, I would ask what the infrastructure cost differential is between India and the United States. We have some control over nursing costs, but very little control over what utilities, real estate, dietary staff, housekeeping staff, or transportation costs. This is a far broader social question than just what we can do within health care.

Health care in the U.S. is clearly disjointed and needs to be integrated so information can flow easily across all theaters of care. This will clearly decrease errors of all kinds, duplication of studies and workups, and will have some influence on decreasing the cost of care. But even if the family practitioner is doing a great job at population management, there will still be an ever-present need for episodic care that is one-on-one and focused on that patient at that moment. Should that be a physician who knows you from previous one-on-one encounters, and has built a relationship with you, or should it be one who is trying to keep up with quality indicators, population monitors and a host of other information streams? Health care is not the auto industry; it’s personal and many facets of it do not lend themselves to an assembly line mentality. Certainly there are many areas we can improve, but let’s not put it all on the backs of our physicians, and let’s not throw out the good (personal care by a physician who knows you) with the bad (a very disjointed system that can’t communicate with itself). I believe we can achieve both.

John R. Mulvey, M.D.
Elkton, MD
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Introduction

Stephen Rockower, M.D.

“These are the times that try men’s souls.” These words by Thomas Paine are just as true now as in Revolutionary times. Medicine in America is at a crossroads. Significant changes are happening, not always what we might think is for the better. The Patient Protection and Affordable Care Act of 2010, sometimes known as “Obamacare,” is only one facet of the enormous challenges facing the way we care for patients, conduct our practices, and structure our professional lives. Electronic medical records (EMRs) are being forced on us. Electronic prescriptions are required. Accountable care organizations (ACOs) are being formed, which may or may not be accountable to anybody. The ways we communicate with patients, each other, and the hospitals are changing daily. The way we communicate with patients, each other and the hospitals is changing daily. The way we classify diseases for reporting to insurance companies (The International Classification of Disease-Version 9, or ICD9) is getting a major upgrade in complexity.

How are we to cope with the daily challenges? Each of us must examine our daily lives and try to grow into the roles thrust upon us. This issue of Maryland Medicine examines the role of physician leadership in Maryland and across America, and provides a blueprint for each of us to step up for the betterment of ourselves, our patients and our profession.

Susan Reynolds, M.D., Ph.D., outlines the roles of physicians as leaders in the community. She traces the changing relationships of physicians in hospitals and other practice settings, while examining the future of physician leaders.

Alice Gosfield, Esq., a health care attorney, notes the plethora of “quality” in the law. Our last issue of the journal (Vol. 12, Issue 2, http://issuu.com/medchi/docs/mmc012issue2) examined quality in greater detail, but suffice it to say, everyone wants quality but no one can define it easily. Ms. Gosfield notes:

1. You cannot improve what you don’t measure,
2. What gets measured gets done, and

We all know the story of the patient who dies, even though all the lab values were normal. As physicians, we need to control the process of measurement, so WE can influence the determination of quality. Gosfield concludes that, “without the drive to make things better for themselves and their patients, and the willingness to commit to change, physicians will inevitably find themselves in … passive posture … as the maelstrom of change they fear sweeps them up in ways they can no longer influence.” Strong words, indeed.

Maryland’s Secretary of the Department of Health and Mental Hygiene, Joshua Sharfstein, M.D., makes the case for Maryland physicians to protect the “unique relationship between doctor and patient.”

continued on page 18
In the one thousand pages of the health reform legislation that have nothing to do with the individual insurance mandate, the vision for America’s health care system is quite different from anything seen before in federal law. There is a significant and fundamental emphasis on the efficiency of care, its value, its effectiveness, and above all its quality. In fact, the word “quality,” including high quality, quality improvement, quality reporting, quality measures, quality data, quality of care and quality performance appears no less than 483 times.

What is Happening?

For the first time in American history, pursuant to the legislation, the government has published a national quality improvement strategy which is not limited to Medicare and Medicaid patients. As part of the value proposition the legislation posits, hospitals are facing a one percent cut across the board in their Medicare DRG payments, no payment for preventable re-admissions, and no payment for a targeted list of hospital acquired conditions. Moreover, under the value-based purchasing program, as calculated for measures associated with a specified list of conditions, top performing hospitals will be paid more than their more mediocre peers.

Unbeknownst to many physicians, they also will be subjected to a value-based modifier for Medicare fee-for-service payment, which form of payment will certainly remain in place for the foreseeable future. While both hospitals and physicians under these programs will be measured initially for their quality alone, for admissions in 2014 for hospitals, and in the same time frame for the physician fee schedule, both will be measured for their efficiency and paid differentially, depending on their scores. For physicians, their efficiency will be determined under a government sponsored, publicly transparent episode grouper which is already in development. This software package will be applied to Medicare claims to identify high value and low value physician performance.

Hospitals and health systems are employing physicians in record numbers. Often they are entering into lucrative (to the physicians) contracts that may or may not be financially sustainable in a quality-driven world where hospitals see far fewer of the admissions which are their bread and butter today. When diabetics are well taken care of in the community, hospitals ought not see many admissions for diabetes, for diabetic stroke, for amputations and the like. There is much discussion of new payment models, although few concrete proposals have emerged. While physicians are anxious about all of these changes and mistrustful of many hospital initiatives, this moment of ambiguity is an opportunity.

The Power of Physician Values

Whether physicians are employed or independent has nothing to do with the potential for health systems and hospitals to transform into high value and high quality enterprises. Those organizations which have demonstrated their ability to produce value assert that “Physician leadership is critical in developing two characteristics which are critical to supporting their ethos: collaboration and accountability.” These organizations have deeply embedded cultures which are physician driven. This does not mean that they have neither chief information officers, nor chief financial officers, nor non-physician administrators in the C-Suite. It means that their physicians are fully engaged with them in governance and operations and drive the clinical culture of these institutions.

The primacy of physicians in these organizations has occurred not only because many of them were created by physicians 75 or more years ago. Rather, these organizations – such as the Scott...
and White Clinic, The Mayo Clinic, the Marshfield Clinic, the Billings Clinic and others—have embraced the idea that physicians hold a unique place in health care. First, they have plenary legal authority which means they have the broadest scope of authority of anyone in the health care system. Hospitals neither admit patients, nor order services, nor discharge patients. Physicians do. Virtually everything that happens in a hospital is ultimately derivative of a physician order. Most patients experience the health care system through their relationship with a physician. The physician is often the portal to the rest of the system making referrals and writing orders that engage all the other providers. Because of this primacy, while many changes in health care can be effected without direct physician involvement, what the current environment demands will not happen without the enthusiastic engagement of physicians. But merely being involved is not enough.

**Toward What End**

The real challenge for physicians is not to lead for the purpose of mere power, but to lead for the purpose of creating true clinical integration. This term, while frequently used in today’s dialogues, is rarely defined. The activity of clinical integration that will be so critical for physician and health care delivery success generally is “Physicians working together systematically, with or without other organizations or professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.”

Real clinical integration—not an antitrust concept, but a deep way of reorganizing clinical processes, compensation, administrative support systems and more—can bring the unique values of physicians to the forefront of health care. Even as those values are critical to improving quality and value, to succeed in the new measured and publicly reported health care system, physicians will need to deploy team based multi-disciplinary approaches to care, with a very clear focus on the patient.

In the developing health care delivery context where all providers will be measured, the results will be transparent and will affect payment; so scoring well will matter. There are three longstanding truisms about quality measurement:

1. You cannot improve what you do not measure.
2. What gets measured gets done.
3. So, be careful what you measure.

Clinical integration is fundamentally about developing data on which physicians can alter their clinical and administrative processes to improve performance. The goal is to facilitate better coordination and interaction among all the parties involved with the patient. The speed and depth with which physicians take up this challenge will have a major impact on the delivery of health care in this country. To standardize more and more to the evidence base while custom-crafting the art of medicine—the application of science to the specific needs of an individual patient—will be the hallmark of successful patient-focused health care. Only physicians can really make this happen, regardless of their organizational context.

**Getting Started**

No matter the setting in which physicians deliver care—whether in small practices, as employees of health systems, in large multi-specialty groups, as the organized medical staff, or in some new organizational configuration with a hospital, in an ACO-like program or a co-management contract—clinical integration will be important. There are at least 17 attributes of clinical integration, the manifestations of which are slightly different depending on context. There is a new, free self-assessment tool available which presents three stages of evolution, from just getting started to fully committed and engaged around these attributes. The document looks at these issues from two perspectives: the stand-alone physician group or health system employed physicians on one hand, and then the organized medical staff or newly coalescing hospital-physician organization. It has proven useful as a starting place for physicians who want to lead the next steps for change, to provide focus on what it will take to get to a new vision of their practice or healthcare delivery context. Using the tool to start a conversation with other physicians with whom physicians seek to work in common cause can be a form of yeast, so to speak, helping physicians to begin to craft a new vision as well as to begin to identify steps to get there.

Where physicians seek to clinically integrate with their hospital or health system partner, it is particularly important for both parties to have direct and frank communication about past efforts at change. It is unusual, in American health care, to find a hospital or health system that has not had some adverse event in trying to engage physicians with them. It is important to identify where past grievances lie in order to confront them and put them in the past. Using a historical assessment tool, dialogue among physicians and with hospital administrators and board members can facilitate their ability to both arrive at a common vision of a new future and be able to articulate the purposes of the engagement with each other.
To get beyond these mere assessments of the current state to actual changed programs, processes and initiatives will require will, energy and time. Physicians often feel that these are the scarest commodities in their lives. But without the drive to make things better for themselves and their patients, and the willingness to commit to change, physicians will inevitably find themselves in a sadly, traditionally passive posture, where they may find themselves soon whining more than they have before, as the maelstrom of change they fear sweeps them up in ways they can no longer influence.

No matter what legislative or budgetary changes unfold in the coming months, this moment in health care change is one of real opportunity for physicians. Knowing that clinical integration is the key to the future provides a predicate for physicians to lead themselves and with others to make health care safer, more effective, of higher quality, and real value. There will never be a moment like this again. Physicians should step up and act.

Alice G. Gosfield, Esq., is a health care attorney in Philadelphia, representing primarily physicians, physician groups and physician organizations. For a complete list of references please email sraskin@montgomerymedicine.org.

References:


In Sickness and in Health: Physicians as Captains of the Ship

Joshua Sharfstein, M.D.
Secretary, Maryland Department of Health and Mental Hygiene

Nearly 15 years have passed, but I still remember sitting, tired and post-call at my kitchen table and answering a page from Leo’s mother. She told me that Leo, a bright school-age boy, had a bad cough and a new left shoulder pain.

The cough was no surprise during flu season, but the shoulder pain? I was perplexed. Leo’s mom regularly paged me with news about Leo and his brother. But this time, something was different. I wondered whether the symptoms could reflect referred pain.

I advised a trip right away to the Emergency Department for an x-ray. The film showed a mediastinal mass, and by the morning, Leo was on his way to Children’s Hospital to receive radiation therapy to prevent a catastrophic airway obstruction.

It was, without question, the best save I made during my pediatric residency. I look back and think about all the steps that made it possible — my close relationship with the family (made possible by my ability to converse with them in Spanish), my willingness to share my beeper number, my ability to refer to care quickly, and strong support from specialists and subspecialists who later saved Leo’s life from acute lymphoblastic lymphoma.

All physicians have similar stories to tell, featuring grateful patients who make it possible to bear the hassles of medical practice. Yet many physicians wonder whether changes afoot make it more likely, or less, for them to do right by their patients.

I wonder too. When families call late at night and get a triage line, are the protocols strong enough to notice the little catch in a mother’s voice in describing her worry for her son? Would an insurer require pre-approval for a late-night x-ray, without a routine indication for why it was necessary? How easy would it be to cut through red tape for a child in desperate need of advanced oncologic care?

Many shifts in the health care system are yielding tremendous advantages for physicians. Advanced health information technology puts the patient’s history and data at the doctor’s fingertips at the point of care. Nurses, social workers, pharmacists and others play critical roles helping patients gain control over their illnesses.

And measurement of quality and outcomes makes it possible for systems to improve over time.

But as things change, what stays the same? Or put another way: what protects the unique relationship between doctor and patient?

Some physicians have sought out "boutique practices" as a path that allows them the time for a real connection with their patients. Good news, perhaps, for the patients who can afford to buy in; bad news for those receiving a note saying they no longer have a doctor.

Other physicians are reaching for new opportunities in today’s health care system — opportunities that provide enhanced autonomy to those willing to share responsibility for their patients’ overall experiences and outcomes.

For example, many primary care doctors are embracing "medical home" models, which provide extra resources to practices that coordinate care among specialists and hospitals. When the patient’s care is handled effectively and efficiently, the primary care doctor shares the credit. If it works, such a role can further the "triple aim”—a better experience of care for the patient, lower costs, and better outcomes.

In the hospital, specialists are taking advantage of "bundled" rates to redesign the care of patients with specified conditions. A data-driven assessment of where complications or other problems emerge can lead to important process changes. New payment approaches incentivize finding creative ways to reduce readmissions and repeat surgeries.

Between hospital and community, there is a role for community-oriented physicians to identify places where collaborative efforts can fill gaps. Recently, Maryland’s Health Care Quality and Cost Council heard an enthusiastic presentation from Dr. Patricia Czapp of the Anne Arundel Medical System. She spoke about efforts to connect patients in the health care system to local resources so that they can remain healthy at home.

Doctors seizing such opportunities are embracing the role of captain of the ship, eager to steer patients to a healthier port — and ready to receive the rewards of a system that increasingly pays for value.

Physicians have much to bring to the table in developing these initiatives, including their sense of what patients need to stay healthy, the ability to lead a team, a comfort level with data and evaluation, and the moral authority to advocate for the patient’s needs first.
Will every new opportunity deliver on its promise? I don’t think that’s something we can take for granted. In Maryland, we will be taking stock of these efforts through a new health delivery reform subcommittee of the health care reform coordinating council. We will create a new website for this effort and link to it from www.dhmh.state.md.us.

Of special interest to me is that as the health care system evolves, practicing doctors will have new reason to be creative about prevention, support effective behavioral change to address common risk factors like smoking and obesity, and monitor outcomes across a panel of patients. In other words, new leaders in medicine will increasingly cross into the territory of public health.

Thinking of Leo makes me miss the time I cared for patients. I am planning to start some clinical work again, as a volunteer. I need to be ready to catch the next catastrophic diagnosis. But I also look forward to keeping my patients healthy.

Dr. Sharfstein is the Secretary of the Maryland Department of Health and Mental Hygiene. His email address is JSharfstein@dhmh.state.md.us and you can follow him on twitter @DrJoshS.
In an interview a few months ago, I likened the medical community to an orchestra. One of the marvels of the symphony is how musicians of diverse backgrounds, playing different instruments and even following different melody lines, come together in a seamless whole. In a similar fashion, the power of organized medicine lies in its capacity to create a unified voice out of the myriad interests it represents.

We are a disparate group, physicians. We hail from different geographic locations, belong to different specialties, and embrace different methods of practicing medicine. In light of these differences, it can sometimes appear that we have little in common. Yet at the heart of our profession is something we all share – a commitment to doing good and serving our patients.

I took my position at the American Medical Association (AMA) because it is here that the myriad voices of America’s physicians are fine-tuned into the one leading voice of organized medicine. The policy-making body of the AMA – the House of Delegates – encompasses representatives from 175 state and specialty societies. While meetings can get heated, and reaching consensus may take considerable time, the democratic nature of the AMA ensures that virtually all physicians have an opportunity to express their opinions. And the result is a powerful voice of leadership.

The AMA has used this voice to shape medicine for more than 160 years. It’s funny though. Perhaps because of its long history, sometimes people forget to pay attention to the AMA – myself included. I thought I knew a lot about the organization when I signed on. Yet in the past few months as I’ve delved into our history, I have been amazed at just how much the AMA has influenced American medical practice:

- One of the newly founded AMA’s first actions, back in 1847, was to create the world’s first code of medical ethics. (This is the AMA’s Code of Ethics. Hippocrates (450-380 B.C.E.) wrote the first code, The Hippocratic Oath). It defined the medical profession and remains at the core of physician practice to this day.

- In 1908, building on 60 years of educational reform efforts, the AMA Council on Medical Education called on the Carnegie Foundation for the Advancement of Teaching to undertake a comprehensive survey of American medical education. The result was the groundbreaking Flexner report, referred to as the Carnegie Bulletin #4, which catalyzed significant reform and set the course of medical education in this country for the next century.

- A decade ago, the AMA convened the Physician Consortium for Performance Improvement (PCPI) to develop measures that doctors could use to improve both the quality and efficiency of care. Today, PCPI has grown tremendously in both scope and influence. For example, last year PCPI authored nearly two-thirds of the quality measures adopted by the Center for Medicare and Medicaid Services in its 2010 Physician Quality Reporting Initiative program.

In this time of historic change for America’s health care system, the AMA is as important as ever. In fact, back in 2007 it was the AMA’s Voice for the Uninsured Campaign that first drew national attention to the millions of Americans who lack health insurance. Our advocacy was a catalyst for action and by 2016, 32 million men, women and children will gain access to health insurance as a result.

Today the AMA is committed to ensuring that health system reform functions optimally for both physicians and the patients under our care.

- We have vociferously opposed the Independent Payment Advisory Board that would mandate pay cuts for physicians.

- We are also pushing the Federal Trade Commission and Department of Justice to change their proposed policy, so that physicians in all practice sizes can develop, lead and actively participate in ACOs and other new delivery models.
The Physician Leadership Imperative: New Opportunities for Physician Leaders Due to Health Care Reform

Susan Reynolds, M.D., Ph.D.
President and CEO
The Institute for Medical Leadership

New Models of Health Care Delivery Require More Physicians in Leadership

Healthcare Reform is here to stay, and although many physicians are fearful that change may bring more reimbursement cuts and administrative hassles, there are significant opportunities for physician to rise into emerging leadership positions. The Affordable Care Act (also known as ACA, PPACA, or Obamacare) has brought to the forefront several new models of healthcare delivery and reimbursement. Among the new models are accountable care organizations (ACOs), and medical homes value-based purchasing (payment based on outcomes that meet national quality standards), bundled payments, and readmission non-payment.

President Obama’s appointment of Dr. Donald Berwick from The Institute for Healthcare Improvement as head of CMS over the 4th of July 2010 congressional recess without Senate confirmation signaled the administration’s firm commitment to reforming how payment is made to physicians and other healthcare providers. Dr. Berwick’s long-range vision is to shift payment from fee-for-service to payment for outcomes, holding physicians accountable for high quality, cost effective performance.

Only a handful of physicians have been at the table as healthcare policy has been handed down in the form of legislation as well as payment reform mandated by the Centers for Medicare & Medicaid Services (CMS). But as ACA becomes a reality, more physician leadership is clearly needed throughout the reformed healthcare system. Who sets the quality standards and enlists the cooperation of the physician community in seeking better outcomes? And who will be in charge of the new delivery systems? Will physicians, who are best suited to evaluate the quality of clinical care, rise into leadership positions? If so, what new knowledge and new skills will they need to learn in order to be successful?

Traditional Roles for Physician Leaders

Since organized medical staffs were created to assure quality of healthcare, there have been several traditional roles for physicians who became medical staff leaders. These roles include the medical staff officers, namely the Chief of Staff (sometimes called the President of the Medical Staff), the Chief of Staff-Elect, the Secretary/Treasurer, and the Immediate Past President, and are typically defined in the Medical Staff Bylaws. Other traditional physician leadership roles include Department or Division Chairs, who usually serve on the Medical Executive Committee (MEC), and Committee Chairs such as the Bylaws Committee, Credentials Committee, and Utilization Committee, who may or may not serve on the MEC.

New Roles for Physician Leaders

A new role for physician leaders began to emerge in the 1990s – that role of Vice President of Medical Affairs, or Chief Medical Officer. This physician joined the administration as part of the senior management team of the hospital. Quality of healthcare was being defined by a formula that included clinical outcomes and service over cost, and hospital administrators needed help making sense out of clinical outcomes data. They also needed physician support if these measures were to improve, and who better to talk with physicians and get their buy-in than a physician leader.

At the beginning of the 21st century, reimbursement became increasingly linked to data analysis and outcomes reporting. The role of the VPMA/CMO expanded from just being a liaison between hospital administration and the medical staff to being responsible for physician performance. In fact the job has become so big some CMOs are now hiring Chief Quality
Offenders and Chief Patient Safety Officers to assist them with their duties. In larger organizations, physicians may also serve as Medical Directors of Performance Improvement or as Medical Directors of Utilization.

Hospital boards of trustees must focus more and more on quality outcomes in order to maximize reimbursement, and therefore more physicians have been asked to serve as board members. Whereas in the past perhaps a retired physician or a respected physician from another community would serve on the hospital board, now physicians who are active members of the medical staff hold board positions because they can best analyze the quality and outcomes data the board must review.

There is an increasing trend for hospitals to have the Chief of the Medical Staff serve on the board in an ex officio position, sometimes with a vote and sometimes without a vote. It must be pointed out that the fiduciary duties of care, loyalty, and obedience that every board member must uphold also apply to the Chief of Staff. In other words, the chief, who serves as a voting member of the board, must represent the hospital, not the medical staff when it comes time to vote. For this reason, some chiefs of staff opt not to have a vote on the board in order to avoid the inherent conflict of interest they have because of their medical staff leadership position.

Emerging Physician Leadership Roles

In order to handle the large volume of data that needs to be analyzed and due to the American Recovery and Reinvestment Act of 2009 (ARRA), electronic medical record (EMR) systems have become mandatory. Physician input has proved to be essential for the successful acceptance of hospital EMRs. Many institutions are hiring physicians with significant technical backgrounds to be their Chief Medical Information Officers (CMIOs). These positions were part-time initially, but because of the time constraints imposed by ARRA, many hospitals are now hiring CMIOs on a full-time basis.

Many hospitals embarked on the survival strategy of employing physicians in order to have better control over future reimbursement, perhaps arriving in the form of bundled payments. Medical groups ranging in size from of 50 to 250 or more physicians are being developed rapidly and require strong physician leadership in the form of group medical directors and/or CMOs as well as service line medical directors and site medical directors.

The accountable care organization (ACO), a new model of healthcare delivery, requires significant roles in governance for physicians. Although the original ACO model was soundly rejected by 93 percent of the American Medical Group Association’s members in May 2011, a revised model called the Pioneer ACO has garnered more support. Many organizations are now developing their own ACOs, and physicians in governance must clearly understand their new oversight duties and responsibilities.

A recent study by Amanda Goodall, Ph.D., showed that hospitals run by physician CEOs had approximately 25 percent better quality outcomes for cancer, digestive disorders, and heart surgery than hospitals with non-physician CEOs. More data is needed to assess if a trend towards more physician CEOs will emerge.

What New Knowledge?

With so many new roles emerging for physician leaders, what new knowledge and what new skills do they need to learn in order to be successful? One of the first things they must learn is how healthcare reform will affect their organizations and physician practices. Looking at national and local healthcare trends will also provide a good framework for future strategic planning efforts.

Physician leaders must also stay current with the knowledge traditionally required of medical staff leaders. This knowledge base includes: medical staff leadership responsibilities; the credentialing and privileging process, including what is negligent credentialing; effective peer review and how to use outside peer review organizations; the latest from The Joint Commission, updated yearly; new quality and patient safety initiatives and how to implement them; and hospital finance including the physicians’ impact on the hospital’s bottom line.

Evolving roles require additional knowledge about new models of care delivery; LEAN/Six Sigma methodology for eliminating organizational waste; advanced hospital finance and budgeting; human resources regulations; and specific technical expertise depending on the position.

What New Skills?

A field study done by senior MBA students at the UCLA Anderson School of Management showed that the top success factor for physician leaders was building trust. Also near the top of the list were communicating one-on-one, teamwork, and communicating to different types of people in different settings. The study also showed that the functional management skills the physician leaders needed for success were healthcare policy, healthcare economics, data analysis, information management, and financial management.

Why were building trust, communication skills, and teamwork so important for success? Physician leaders have always had a difficult role in that they must maintain strong ties with their clinical colleagues while building new ties with administration (sometimes viewed as the dark side by their fellow physicians). If they are merely seen as a puppet of administration, they lose their credibility with their clinical colleagues. If administration views them as autocratic doctors rather than team players, physicians may experience “tissue rejection” from the management team. The most successful physician leaders can bridge the gap between the medical staff and administration and at best narrow that gap effectively.

Additional skills emerging physician leaders must develop or improve include: motivating physicians, conflict resolution, dealing with disruptive behavior, emotional intelligence, creative problem solving, physician coaching, understanding and mentoring Generation Y, meeting management, and improving physician/hospital relations.

The above list of new knowledge and new skills is a good place to begin for any physician seeking a new leadership opportunity. Advanced degree programs such as the Masters in Medical Management and the Physician Executive MBA have been developed at several academic institutions for those physicians seeking a comprehensive learning experience.

Summary

During times of change there can be danger, but also opportunity. Such is the case now for physician leaders. Physicians are needed in numerous leadership positions as the healthcare
system is reformed, and new roles for physicians emerge on a regular basis. If physicians want to succeed, they will need to learn new skills and acquire more knowledge. They may even want to obtain an advanced degree in order to maximize their effectiveness. Carpe diem!

References:

1. A. Goodall, Social Science and Medicine, August (2011) pp 535-539.


Susan Reynolds, M.D., Ph.D., is President and CEO, The Institute for Medical Leadership and a former White House advisor, CEO of an emergency medical center, and executive search consultant.

Introduction...

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Dr. James Madara, Executive Vice-President and Chief Executive Office of the American Medical Association (AMA), outlines the history of physician leadership in the United States, and the AMA’s role in changing the face of medicine and medical education over the past century and a half. He outlines the AMA’s vision for future leadership to affect changes in the “Sustainable Growth Rate” (SGR) and e-prescribing. Most importantly, he makes the case not to be complacent, and to join with organized medicine to adapt to and work to influence the changing world.

Louis Goodman, Ph.D., and Tim Norbeck of the Physician’s Foundation argue for physician involvement and leadership. They conclude that, “more than ever before, physicians must be vigilant and active participants in their medical societies [italics added] because they provide the opportunity for collegiality, debate, dialogue, and development of consensus.”

Robert Kocher, M.D. and Nikhil R. Sahni, B.S., in an article reprinted here from The New England Journal of Medicine, argue that physician leadership and control is needed for the upcoming ACO model of healthcare. They outline perils, pitfalls and potential profits of an ACO, but note the complexities of forming and maintaining such organizations. To them, the race goes to the swiftest who take initial control and shape the future.

As another leader in tumultuous times, Benjamin Franklin, once said, “We must all hang together, or assuredly we shall all hang separately.” Now is the time to become active in medical society affairs, at the local level, at the state level or nationally. Join. Get your friends and colleagues to join and be heard. We have only ourselves to blame if events do not fare as we wish. We all can be leaders. Do it.

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The Physicians Foundation was created in late 2003 as part of the settlement in a successful lawsuit against the managed care industry. It is a non-profit (501(c)(3)) organization that focuses on the following core areas: health system reform, physician leadership and workforce needs. As the health system in the United States continues to evolve, The Physicians Foundation is steadfast in its determination to foster the physician-patient relationship, assist physicians in sustaining their medical practices during this evolution, and to aid physician leaders in their organizations or at a grassroots level to impact policy changes or develop innovative programming to improve health care delivery.

When we visit with state medical societies, a prominent issue is often the need for leadership education for their physician officers. It is no longer sufficient to just be outstanding physician leaders; the demands of the new environment require elected officers to also be knowledgeable on strategic planning, negotiations and crisis management. Therefore, the Physicians Foundation is partnered with Northwestern University's Kellogg School of Management to offer a Leadership Academy to leaders of state medical societies. To date, two groups have completed the session; the next Academy will be held in May 2012.

For physicians to be effective leaders, they need information, an understanding of the market forces, and greater understanding of the challenges Medicine is facing beyond their own experience. To this end, the Physicians Foundation surveyed physicians in 2008. Their findings were reported in the winter 2009 issue of Maryland Medicine (“Taking the Temperature of Medicine: The Data Tells the Story”). Since that time, there has been a 2010 follow-up physician survey as well as other interesting projects. Both surveys revealed a deep sense of physician frustration, stress and anxiety. Navigating an increasingly hostile practice environment was causing widespread dissatisfaction and low morale. In the wake of burgeoning insurance red-tape, decreasing reimbursements and increasing government regulatory measures – plus the constant threat of a liability action – physicians were having serious problems sustaining their medical practices.

The Affordable Care Act (ACA), passed by Congress in 2010 added to physicians’ sense of concern. With its myriad of provisions affecting physician practices, not to mention its length and sheer comprehensiveness, physician angst only multiplied. Economist Milton Friedman’s comment about the inefficacy of government comes to mind. If you put the federal government in charge of the Sahara Desert, he said, in five years there would be a shortage of sand. In taking over the U.S. House of Representatives in the mid-term elections, many newly elected Republicans campaigned against the ACA. The future of this health reform legislation is somewhat in doubt, as court challenges have been mounted in numerous states.

With this physician uncertainty, and in light of the unstable political landscape, The Physicians Foundation commissioned Bostrom, a well-respected national association management and professional services company, to produce a white paper examining the provisions of the ACA and how they would impact physician practices. This non-partisan Roadmap for Physicians was designed to answer questions and help them to better navigate the practice uncertainties ahead, and to help their professional societies respond to their members’ needs effectively. The Roadmap (http://www.physiciansfoundation.org) focuses on the legislative changes that hold the most significance in the daily practice of medicine, such as changes in the payment systems, quality reporting, shared savings programs, workforce and rural initiatives, and select aspects of the changes reshaping the private health insurance market. It is important to note that, despite what actions are taken by Congress to amend the ACA, most of the provisions affecting physicians will most likely endure in some form.

A few of the broad shifts included in the Roadmap that these health care changes represent are:
Physicians will increasingly lose the “private” in private practice;
• Significant numbers of physicians may feel compelled to relinquish private practice autonomy in favor of networks or group formations;
• Physicians will assume greater responsibility for the health of populations, not individuals;
• Physicians could become a link for risk-bearing arrangements, thereby assuming significant shared financial risks and quasi-insurance roles;
• Physicians will face increased legal compliance obligations and potential new liability challenges under federal fraud and abuse statutes;
• Physician shortages will be exacerbated, causing decreased access to care in many parts of the country; and
• It is highly unlikely that the ACA will alleviate physicians of the pressure of declining reimbursements on one hand and sharply rising practice costs on the other. In fact, those problems most likely will become worse.

We believe that this Roadmap for Physicians provides valuable information on select delivery systems and payment provisions that will fundamentally alter how physicians organize, practice, and deliver care in the future. Some of these provisions have clear and direct consequences, such as changes to physician reimbursement and the adoption of electronic medical records. Other provisions create new structures and entities, such as the CMS Center for Medicare and Medicaid Innovation, the Independent Payment Advisory Board, and the Patient-Centered Outcomes Research Institute. Others lay a foundation for alternatives to traditional fee-for-service payment, such as the National Pilot Program on Payment Bundling and the shared savings program (including the much-discussed accountable care organization model (ACO)). In addition, the Roadmap provides a valuable tool to physician leaders and their organizations to address issues at the state and federal levels as they advocate for physicians and patients with legislators, regulators, media and the public.

The full research report is available for download on The Physicians Foundation website at:www.physiciansfoundation.org.

In addition to being well informed, physician leaders must be active in the health policy arena to ensure that policymakers understand the impact of their decisions on the provision of quality medical care. The Physicians Foundation has been very active awarding grants to ensure that adequate data is available to support policy changes. The Physicians Foundation has given grants of over $28 million since 2004. One grant of nearly $750,000 has been pledged in North Carolina to develop a dynamic, web-based projection model that can be continually updated to track ongoing physician workforce needs across the country.

The Affordable Care Act (ACA) seeks to extend insurance to more than 30 million people, something all Americans support in principal. Given this influx of new patients, however, policy makers and physicians will need to know where physician shortages will be especially acute. Most experts agree that the nation already faces a severe deficit of physicians. Information gleaned from the North Carolina research will further enhance efforts to identify where physicians are most needed to support patients in a growing healthcare system. It will appear on The Physicians Foundation website when it becomes available.

All too often physicians are routinely blamed for increasing costs and poor outcomes. Changes in this commonly-held perception are often difficult to accomplish. However, sustained grassroots leadership efforts have the potential to make inroads in changing this perception, such as through development of innovative programming like that of Health Leads of Boston, Massachusetts. One of Health Leads’ main purposes is to develop the capacity to address the intersection of poverty and poor health. Its founder, Rebecca Onie, interviewed local physicians about their needs in providing patient care. Many were frustrated that they could not help their poor patients beyond simply providing medical care—with housing, nutrition (food) or other resources that could improve their health. Not only have these important issues been excluded from the health reform debate, they are largely ignored by everyone.

With a grant from The Physicians Foundation, Health Leads expanded their efforts to train college student volunteers in five cities to “assist” physicians to “prescribe” food, housing and fuel assistance, or other resources for their patients—just as they do medication. Patients then take those “prescriptions” to the Health Leads Family Help Desks located in clinic waiting rooms, where the volunteers “fill” them by connecting patients with these resources. Most of the student volunteers (64 percent of whom are pre-med students) end up choosing to go into primary care.

The recent health care reform legislation, combined with the economic and regulatory demands on physicians, is having a profound effect on the organization of medical practice. The vast majority of physicians are no longer looking to practice in solo or small group settings. Instead, physicians in increasing numbers are joining large groups or becoming employees of hospitals and large health care systems. Given that most state medical societies are organized to provide services to independent or group-based physicians, The Physicians Foundation is interested in helping those societies transform into medical societies of the future. This will provide distinctive solutions to the problems physicians face in the care of their patients as the medical practice environment rapidly evolves. The Physician Foundation stands ready to be an active partner with physician leaders to help them accomplish this transition successfully.

These are perilous (yet opportune) times for physicians and physician leaders. With diminishing bargaining power with insurers, onerous regulations and red tape, increased practice expenses, declining reimbursements, the liability threat and demands to practice “cookbook” medicine, The Physicians Foundation can offer substantial assistance. The opportunities are vast for innovation and program development also at the point of health care delivery, or in organizations. More than ever before, physicians must be vigilant and active participants in their medical societies because they provide an opportunity for collegiality, debate, dialogue and development of consensus. Likewise, physician leaders are faced with new challenges as they help their organizations and their colleagues to navigate the new paradigm that defines the medical profession.

Physicians cannot afford to sit back and “hope that something will turn up,” like the fictional Dickens character, Wilkens Micawber. Complacency never worked for Mr. Micawber—and it won’t work for physicians or physician leaders either...especially now.

Louis J. Goodman, Ph.D., serves as President of The Physicians Foundation, & Executive Vice President of the Texas Medical Association. Timothy B. Norbeck, is CEO of The Physicians Foundation and former Executive Vice President of the Connecticut State Medical Society.
Physicians versus Hospitals as Leaders of Accountable Care Organizations

Robert Kocher, M.D., and Nikhil R. Sahni, B.S.

Enactment of the Affordable Care Act (ACA) was a historic event. Along with the Recovery Act, the ACA will usher in the most extensive changes in the U.S. health care system since the creation of Medicare and Medicaid. Under this law, the next few years will be a period of what economists call “creative destruction”: our fragmented, fee-for-service health care delivery system will be transformed into a higher-quality, higher-productivity system with strong incentives for efficient, coordinated care.1 Consequently, the actions of physicians and hospitals during this period will determine the structure of the delivery system for many years. The implications will be profound for hospitals’ dominant role in the health care system and for physicians’ income, autonomy, and work environments.

The ACA aims to simultaneously improve the quality of care and reduce costs. Doing so will require focused efforts to improve care for the 10% of patients who account for 64% of all U.S. health care costs.2 Much of this cost derives from high rates of unnecessary hospitalizations and potentially avoidable complications,3 and these, in turn, are partially driven by fee-for-service incentives that fail to adequately reward coordinated care that effectively prevents illness. The ACA includes numerous provisions designed to catalyze transformation of the delivery system, moving it away from fee for service and toward coordinated care (see table.)

These provisions will result in incentives for the development of the information systems and infrastructure necessary for better and more efficient management of chronic conditions. Such outpatient changes will be reinforced by hospital readmissions policies that improve handoffs and by initiatives to reduce the occurrence of hospital-acquired infections and “never events.”

The desired consequence of these changes is enhanced tertiary prevention, leading to substantial reductions in unnecessarily expensive specialty referrals and tests and avoidable complications. And the ultimate consequences should be significant improvements in health and fewer exacerbations of chronic illnesses.

Achievement of this level of care coordination will require the development of larger integrated delivery organizations—preferably, accountable care organizations (ACOs) that incorporate primary care practices structured as patient-centered medical homes and that can support new investments in information systems and care teams and can maintain service hours resembling those of retailers.4 A move toward ACOs will mean major changes in the structure of physicians’ practices, since even physician-group–based ACOs may include one or more hospitals, though they may instead contract with hospitals for specific services chosen on the basis of their relative value.

Larger ACOs are likely to be contracted directly by payers to manage the continuum of care. They are also likely to bear financial risk, receiving greater payments for the care of chronically ill patients and accepting at least partial responsibility for the costs of specialists’ visits, tests, emergency room visits, and hospitalizations. Memories of the inflexible managed-care gatekeepers of the 1990s could lead to theoretically permissive, if practically narrow, networks of providers, although these organizations will need to work closely with a small group of efficient specialists and facilities to achieve their quality and efficiency goals.

A crucial question is who will control these ACOs. We can envision two possible futures: one of physician-controlled ACOs, with physicians affiliating and contracting with hospitals, controlling the flow of funds through the marketplace; and one of hospital-controlled ACOs that will employ physicians. Whoever controls the ACOs will capture the largest share of any savings. For physicians to control ACOs, they would have to overcome several hurdles. The first is collaboration: ACOs will require clinical, administrative, and fiscal cooperation, and physicians have seldom demonstrated the ability to effectively organize themselves into groups, agree on clinical guidelines, and devise ways to equitably distribute money. Nearly three quarters of office-based physicians, representing nearly 95% of all U.S. practices, work in groups of five or fewer physicians.5 Since much of the savings from coordinating care will come from successfully avoiding tests, procedures, and hospitalizations, the question of how to divide profits among primary care physicians and specialists will be contentious. Proceduralists who would end up losing income are likely to resist key structural changes.

In addition, ACOs will require sophisticated information technology (IT) systems and skilled managers in order to hold clinicians accountable. Historically, doctors have not shown the willingness to assume more capital risk or to invest in overhead. Finally, memories of the failed capitation models of the 1990s may make some physicians hesitant to participate.

If hospitals are to control ACOs, they, too, will need to overcome barriers. First, they will need to trade near-term revenue for long-term savings. Hospitals are typically at the center of current health care markets, and by focusing on procedures and severely ill patients, most have been fairly profitable. Building an ACO will require hospitals to shift to a more outpatient-focused, coordinated care model and forgo some profits from procedures and admissions. Hospitals’ decisions will be further complicated if payers do not change their payment models similarly and simultaneously.

Second, hospitals, which have generally struggled to operate outpatient practices effectively, may have difficulty designing ACOs. Acquiring practices...
and hiring physicians as employees typically reduce the physicians’ incentive to work long hours and, therefore, reduce their productivity.

It is unlikely that one of these ACO models will dominate throughout the country; local market conditions will influence which one prevails in each community. In geographic areas where the physician base is fragmented and physicians are unlikely to collaborate or where there are already well-established hospital-based health systems, hospitals are likely to dominate. In areas that have well-functioning physician groups, with working IT systems and effective management systems, physician dominance seems more likely. In many other markets, the future is open. In these places, hospitals have the advantage, since they traditionally have more management talent, accounting capability, IT systems, and cheaper access to capital than do physician groups.

Holding off on creating ACOs is likely to be a bad long-term strategy for physicians. First, health care reform has passed, bringing extensive changes, and it would be very difficult to repeal or modify the ACA so as to delay reforms. Congress’s pay-as-you-go rules would require lawmakers to find equivalent savings if they discarded ACA provisions that were expected to save health care dollars — especially at a time when there is tremendous pressure to use any available savings to reduce the deficit. Moreover, policies pursued by the new Independent Payment Advisory Board will probably increase the pressure on providers to coordinate care and form ACOs. Finally, private health plans are facing even more pressure from employers and state insurance commissioners to control premiums.

Established institutional relationships tend to persist because of “path dependence”: decisions about the future are constrained by decisions made in the past, even though circumstances may change. Although it is unequivocally inefficient, inequitable, and otherwise problematic to finance health care with a combination of employer-based coverage, Medicare, and Medicaid, it has proved impossible to change this structure. Similarly, once the new payment system and other changes included in the ACA transform the relationship between hospitals and physicians, the new order will become entrenched and persist until the next period of creative destruction.

If physicians come to dominate, hospitals’ census will decline, and their revenue will fall, with little compensatory growth in outpatient services, since physicians are likely to self-refer. This decline will, in turn, lower hospitals’ bond ratings, making it harder for them to borrow money and expand. As hospitals’ financial activity and employment decline, their influence in their local communities will also wane. And it will be hard for them to recover from this diminished role.

Conversely, if hospitals come to dominate ACOs, they will accrue more of the savings from the new delivery system, and physicians’ incomes and status as independent professionals will decline. Once relegated to the position of employees and contractors, physicians will have difficulty regaining income, status, the ability to raise capital, and the influence necessary to control health care institutions.

Therefore, the actor who moves first effectively is likely to assume the momentum and dominate the local market. A wait-and-see approach could succeed if the first mover executes poorly, failing to coordinate care and manage risk. But rather than controlling destiny, cautious actors will be hanging their fate on the mistakes of others.

In the early 20th century, the health care system changed dramatically with the introduction of antisepsis and the increasing safety and success of surgery: hospitals gained power as they became associated with hope and health rather than fear and death. Now, after decades of hospital hegemony, we stand at another crossroads; physicians may be able to gain market leadership if they move first. How the development of ACOs plays out over the next few years is likely to have lasting implications for the practice of medicine, patients’ experience of health care, and health care costs in the United States. The next decade will be critical for developing an effective model and making historic changes in the structure of our health care system.
In the mid 7th century Ethelreda, the 14-year-old daughter of the king of East Anglia, was wed to Tonbert, Prince of South Gyrwas. The bride, whose piety was surpassing, had made a vow of chastity and the marriage was never consummated.

After Tonbert’s death, her father forced Ethelreda to marry again for dynastic reasons – this time to Egfrid the Prince of Northumberland. However, Ethelreda escaped and fled to the island of Ely where she founded a nunnery, and became the Abbess. Her life was austere, spent in prayer and fasting, exemplary in every detail. Unfortunately, Ethelreda developed a large tumor of the neck and died at age 47. Her life of purity, dedication and piety and the expression “St. Audrey’s” became an emblem of inferior workmanship.

Since childhood, Ethelreda had been called Awdry (sometimes spelled Audrey), which was an affectionate pet name. Therefore, she was known to everyone as St. Audrey, and became the patron saint of those with neck and throat disorders. For many years following her death, the county fair in her home district of Ely displayed an exhibit of lace necklaces. These were made by local housewives devoted to St. Audrey’s memory, and were known as St. Audrey’s lace. Unfortunately, as time passed, patronizing and priggish highbrows became contemptuous of the crude, semiskilled lace handshake produced by the local women, and the expression “St. Audrey’s” became an emblem of inferior workmanship.

Eventually, as often occurs in linguistic evolution, the “S” was dropped from St. Audrey (a process known as apocope), and the term taudry or “tawdry” was born – a word meaning gaudy and cheap – an unfortunate outcome for poor Ethelreda.

Aphesis, the loss of one or more letters from the front of a word, may be noted in the word till from “until,” lone from “alone,” coon from “raccoon,” squire from “esquire,” and cute from “acut.” The term aphesis stems from Greek apo: “away,” and herein: “to take,” that is “to take away.” It is also noted in such medical terms as plasmapheresis and lymphapheresis, and plateletapheresis (or thrombopheresis), procedures in which plasma, lymphocytes, or platelets are removed from the blood.

In 1247, the Priory of St. Mary of Bethlehem opened in London. By 1375, the Priory had become a royal hospital, and in 1547, Henry the 8th granted the hospital a charter to serve as a sanatorium for the insane. Treatment of those patients often consisted of chaining them to a wall, whipping them, immersing them in water (early “waterboarding”), and various other “medical” treatments. Meanwhile the name of the hospital had undergone gradual alteration. British jargon foreshortened “Bethlehem” to “Bethlem,” a linguistic process known as elision (in which one or more letters are dropped from the interior of a word). Londoners often enjoyed a Sunday outing by gathering outside the hospital, listening to – and often inciting – the screams, epithets and caterwauling of those unfortunate inmates. Thus was created a new word – from Bethlehem to Bethlem to bedlam – a place with noise and confusion.

During Shakespeare’s era (1564-1616), the stage entrance of an actor and his moment to speak was marked in the script by the letter “Q” – that letter standing for the Latin quando: “when,” i.e. when to enter or say one’s lines. In original copies of Richard III (1591) “Q” can be noted in the margins of the manuscript, but by the time Shakespeare had written Hamlet (1599) the prompt was spelled out as “cue.” Thereafter, the spelling gradually changed to “cue,” and so it remains to this day.

A pool cue, on the other hand, is derived from French queue: “tail,” which in turn stems from Latin cauda (as in cauda equina). Queue was also used to refer to a braid of hair or a “pigtail,” which often resembled the tail of a horse. The sense of a pool stick stems from some imaginative author who felt that the billiard stick resembled a tail. The sense of a line of people waiting to enter a restaurant or theater, derives again from some whimsical author who visualized such a procession as resembling the tail of an animal. Having occasionally been caught in such extended lines, I consider cue to be an apt metaphor for all of us in that entourage.

A clew is a ball or skein of yarn or thread. The word stems from the Dutch word kluwen. In Greek mythology, the hero Theseus entered a subterranean labyrinth in order to find and destroy the Minotaur, a fearsome beast half man and half bull. (The term Minotaur derives from (King) Minos plus taurus, the Latin term for “bull.” Aphrodite had caused Pasiphae, the wife of King Minos, to fall madly in love with a white bull. Her subsequent copulation with that animal resulted in the birth of the Minotaur.)

Unfortunately, the labyrinth was so complex that no one who had ever entered was able to find his way out. Ariadne, Minos’ daughter, had fallen in love with Theseus and she gave him a clew of gold thread, which he unraveled as he entered the labyrinth. After killing the Minotaur, Theseus followed the thread back to the entrance of the labyrinth and escaped. Thus someone who follows a clew, often unravels a mystery. At time passed, the word clew became clue – another fascinating instance of linguistic evolution and the transformation of a word’s meaning.

The pronunciation of British words is often confusing. In addition to aphesis, elision, and apocope (loss of one or more sounds from the end of a word, as in “psych” for psychology or “chem.” for chemistry), the British have a penchant for unusual and unexpected pronunciations. For example, the town of Aldeburgh is pronounced “Albra,” the village of Athelstaneford is pronounced “Alsanfard,”

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Godmanchester is pronounced “Gamster,” Kirkcudbright is pronounced “Karkoobree,” and the town of Ravenstruther is pronounced “Renstray.”

In the first century of the Common Era (A.D.), a Hebrew girl was born in the town of Magdala, on the western shore of the Sea of Galilee (currently called Lake Tiberias). Her name was Miriam, which in Latin translation became Mary. Thus she has become known to the world as Mary from Magdala – or Mary Magdalene. In paintings by Caravaggio, Carracci, and others – as well as in sculptures by Canova and Donatello – she is depicted as distraught, weeping and grief stricken. As time passed, it became common to refer to someone who was inconsolably tearful as a “Magdalene.” The French version of Magdalene is Madeleine, which was borrowed by the English to become Madeline. However, in keeping with British patois, the pronunciation was altered and Madeline became “maudlin.” Today a person is said to be maudlin if they are tearfully sentimental (This is occasionally influenced by ethanol).

One final example of transformation, in which a word completely changes its original meaning, is philander – defined in Webster’s New World Dictionary as: “to engage lightly in passing love affairs; to make love insincerely; it is said of a man.” The term derives from Greek philos: “loving” and andros: “man” (as in androgen). The original intent was to describe someone who loves a man (for example, a loving wife), but the term has obviously undergone a dramatic shift in meaning. It now refers to a man who does the loving (however shallow and insincere). Philander was the name of a character in several 18th century plays, one who engaged in flirtations and promiscuity. The authors named that character incorrectly, assuming that the word meant “a loving man,” not “one who loves a man.” But the error became fixed in our lexicon, a complete reversal of its original intent.

Incidentally, the Greek root philos (“loving”) may be found in numerous words such as philosophy (“lover of wisdom”), philanthropy (“lover of mankind”), philharmonic (“lover of music”), and philodendron (“lover of trees” – the plant is an evergreen that clings to trees). However, philos is rather hidden in words such as the name Phillip, a combination of philo and hippos: “one who loves horses,” and philtrum, the vertical cleft in one’s upper lip. Ancient Greeks thought it acted as a “love potion.” I vaguely remember that it often does.

In the course of human history, English speakers have altered the pronunciation and the sense of many words. We are verbal alchemists, creating new meanings from old, transforming our lexicon, a complete reversal of its original intent.

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