

Pennsylvania Academy of Family Physicians Lecture Series

“21 Strategies to Survive in the 21st Century”

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Over the course of the past several months, I have had the privilege of addressing family physicians in the eastern part of Pennsylvania in a series of dinner CME presentations entitled “21 Strategies to Survive in the 21st Century.” These presentations have been made on behalf of the Pennsylvania Academy of Family Physicians (PAFP).

Each year, the PAFP sponsors a series of regional meetings throughout the state designed to inform its members on topical areas of importance. During the previous two years, the lecture series addressed “Pay for Performance” and “Electronic Medical Records. While “21 Strategies to Survive in the 21st Century”¹ may seem at first a dramatic assessment of the current state of family physicians, it captures the essence of the state of affairs for many family physicians given decreasing reimbursement and the many changes currently taking place in healthcare throughout the state and the country. I would like to share with you additional background of the presentations and some of my observations gleaned from dialogue with attendees.

The theme and title for the lecture were developed by Patricia Bricker, the Director of Practice Advocacy for the Pennsylvania Academy of Family Physicians and Foundation. The book “Practicing Medicine in the 21st Century,” recently published by the American College of Physician Executives and edited by David Nash, MD, Chairman of our Department of Health Policy at Jefferson served as the basis of the content of the presentation. Given the topical, educational and practical perspectives of the book, Pat concluded that this was the perfect vehicle for communicating a variety of important updates and messages to family physicians throughout the state. With that, a presentation was developed which outlined in the introduction our impression of the societal factors coalescing in a “perfect storm” to drive the current rapid pace of change in healthcare, followed by twenty- one specific strategies to adapt to those changes.

The strategies were organized around the themes used in the five section headings of the book, namely: Clinical Management (Quality, Safety, Pay for Performance), Information Management (Electronic Medical Records, E-Prescribing), the Practice Environment (Risk Management, Managed Care, Medicare and Medicaid, Disease Management), Practice Management (Open Access Scheduling, Operational Organization, Workflow Process Re-engineering), and Financial Management (Documentation, Coding, Billing, Accounting Tools). Our goal in developing the presentation was not only to provide updates on policy related initiatives, but to provide concrete suggestions relating to quality, safety, and practice organization that could enhance the practitioners' financial bottom line through enhanced revenue opportunities and savings on office expenses through more efficient practice processes. The presentation was delivered in such a fashion as to facilitate questions, comments, and interaction between and among the presenter and the audience.

I must confess that I was surprised to learn of the lack of awareness, preparedness, or implementation on behalf of the family physicians of many of the major policy initiatives underway. For example, when questioned concerning their awareness of the existence of the Physician Quality Reporting Initiative (PQRI-Medicare's voluntary Pay for Performance program), approximately 50% responded affirmatively. And while half of the physicians had heard of PQRI, only approximately 5% indicated they planned to report on any of the quality measures. In other areas, approximately 10% of the attendees were using electronic medical records, with the remainder showing little inclination toward adopting this technology. Electronic prescribing was being utilized by less than 5% of the attendees. There was little knowledge of the general theme of consumer directed health plans. The role of the Institute of Medicine in transforming public awareness of quality and safety issues through its two seminal publications "Crossing the Quality Chasm"² and "To Err is Human"³ was essentially unknown to the attendees. And while many of the physicians were aware of and felt threatened by the emerging trend toward "Convenient Care Clinics," they generally had little or no insight as to their role in fostering the development of this movement by virtue of their office practice patterns, and had even less insight as to strategies concerning what to do about it. As to increasing office efficiency through process re-engineering, the general reaction was that physicians did not have time for such activities, were not trained to manage them and could not afford to bring in outside consultants to carry them out.

I would like to focus especially on the feedback concerning the PQRI. This is a major policy initiative in this country which I believe has merit on many levels. If the PQRI initiative follows the path of the Hospital Quality Reporting Initiative, it will be first voluntary and then mandatory, and likely tied to Medicare reimbursement rate increases.

If the PAFP physicians' participation in this program is indicative of participation nationwide, when the program is reviewed after this trial, it will not be considered a success.

I feel that this program may have been implemented too rapidly to address the details that will maximize its opportunity for success. Indeed, there are currently two bills before Congress, the Voluntary Medicare Quality Reporting Act introduced in the Senate by Sen. Ben Cardin, D-Md. and Sen. Arlen Specter R-Pa., and companion legislation introduced in the House by Reps. Bart Gordon D-Tenn. and John Shadegg R-Ariz., that would give Medicare officials more time to figure out how best to run a voluntary quality reporting program and prevent the program from becoming mandatory in 2008. In a statement released when the bill was introduced in May 2007, sponsor Sen. Cardin said, "Current law does not provide sufficient time to assess the appropriateness and effectiveness of this new system. Nor [does it] take into account the fact that most physicians and other health professionals have no experience in quality reporting and do not have in place the necessary health information technology and administrative infrastructures to participate in a reporting system."⁴ In addition, Sen. Cardin noted the difficulties some medical practices would face if a reporting program became mandatory in 2008. "Across America, there are practices that would face tremendous obstacles in meeting such standards: they lack the information technology necessary to document and report standards in a timely manner; they see patients with economic and language barriers that will result in higher noncompliance rates; they treat a patient population for whom ethnic and racial differences require different clinical interventions than for other patients," Sen. Cardin said. "Ignoring these considerations will not only fail to dramatically improve quality, it will significantly penalize providers who treat the traditionally underserved populations."

Clearly, in this regard, Sen. Cardin has his finger on the pulse of what I have observed in my PAFP lectures throughout Pennsylvania.

If you have comments on this article, please contact me at richard.jacoby@jefferson.edu.

References

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