

Missouri Chapter GOVERNOR'S NEWSLETTER

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

Spring 2006

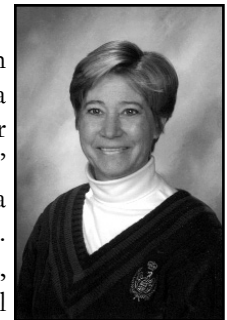
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Governor, Missouri Chapter

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FROM YOUR GOVERNOR.....

The spring Board of Governors meeting in Philadelphia brought glimmers of hope to a worsening situation. Being good internists your immediate question is "where is your evidence" The ACP has a plan to revitalize medicine, a concept called the Advanced Medical Home. The political climate is set for change as Congress, the payers, the doctors, and the consumers are all displeased with the status quo, so- "let the remaking of American Medicine begin."



Steven E Weinberger, MD, FACP - ACP Sr. VP Medical Knowledge and Education Division - discussed the redesigning of Internal Medicine. "Days of iron men" attracted best and brightest to Internal Medicine. The in-patient world was the center of universe. The previous focus of training was on knowledge base and not high quality care. Now contrast this with four types of internist today - the sub-specialist, the hospital-based, the ambulatory-based, and the pluripotent internist. Now training is being driven by service needs and teaching gets shortchanged. Residents learn ambulatory skills in poorly functioning ambulatory clinics. As far as Medical Students career choices in 1998 54% of students chose Internal Medicine whereas in 2005 only 20% of the fourth year students plan to go into Internal Medicine. Clearly medical students are important our long term survival. Medical students need early exposure to effective role models and real life ambulatory care training. Redesigning of the 4th year to revisit pathophysiology, translation of knowledge into high quality care along with literature interpretation skills would be required. We need to train MD's for 21st century care with QI, team based care, etc.

As far as Graduate Medical Education is concerned the three year residency seems appropriate for all of the varied ultimate career paths. Residencies need both core and customized components of training. The core content must cover the six core competencies required of a career in Internal Medicine. Ambulatory training typically occurs in poorly functioning clinics. Resident clinics are the ICUs of ambulatory medicine. Despite the obvious importance, ambulatory

GOVERNOR'S REPORT CONTINUED

care remains a small component of training. There is a need to disassociate ambulatory experiences from inpatient responsibilities. We need to “emphasize the team-based approach to care.”

The recognition of special expertise such as Hospitalist, Ambulatory Care, and Specialist should occur after a period time in practice and need to be readdressed through the recertification process.

Kevin B. Weiss, MD, FACP spoke on the case for evidence based continuing education with ongoing quality improvement and measurement. Traditional education by lecture is not effective in making changes. Today it is known that there are things that work i.e.: physician reminders, patient mediated interventions; office based educational visits, opinion leaders, multifaceted interventions. Physicians can't do it alone; a team effort is needed to see results. Information regarding practice trends/characteristics is needed with data being returned to the physician, so that the physician can improve his or her performance. This education is not enough we need to change health care/informatics system. The change required will be multifaceted and is moving to practice based team oriented learning. The new incentives for practice based learning are now appearing on the horizon as p4p (pay for performance).

Ed Wagner, MD, MPH, FACP spoke on improving the care of people with chronic illnesses. Today less than 50 % of Americans with major chronic illness receive evidence-based clinical treatments. Less than 50% of patients have satisfactory levels of disease control. A majority of patients over the age of 50 do not perceive that they get adequate care. This is called the quality chasm or gap in health care. Our current care is focused on lab results and/or symptoms and not on longitudinal and preventive care. Communication and coordination is not a priority. We need a continuous “Healing Relationship with a care team and practice system” organized to meet the patients needs. If care were improved today to the best practical level >80% of patients would have regular prevention and effective treatments. The current system of care cannot work because it is oriented to acute illness only.

To achieve meaningful change we need change in four domains: decision support, patient education, information support (disease registry), and changes in delivery of care i.e. the planned visit. An EMR with registry function can help distinguish between high and low performers care teams (physician). These changes require an informed activated patient, with motivation, information, skills, and confidence. It also requires a prepared practice team utilizing patient information, decision support and skills for the patients benefit.

Michael S. Barr, MD, MBA, FACP - ACP Vice President, Practice Advocacy and Improvement - spoke on the concept to the *Advanced Medical Home: A Physician centered, Physician guided Model of Health Care*. This concept was built out of ACP position paper 10/04 (www.acponline.org) and the medical home concept from pediatrics of the 1960's. This will require a voluntary qualification process. A component of this program will be required participation in quality improvement. The driving forces present are: a shortage of primary care physicians, an aging population, a decline of primary care being selected by medical students, increasing healthcare costs, a wide disparity in care, and poor health outcomes. The three driving market forces are cost, quality, and access. Access will become even more significant in the near future with the collapse of the primary care system.

Bob Doherty - ACP Sr. Vice President, Government Affairs and Public Policy - talked about the political barriers and battles. Many physicians benefit from the current system, any changes to Medicare will be budget neutral allowing for a division in the voice of medicine and we will be divided and conquered. Many of the internists currently disadvantaged fear a new system will be worse. There is no agreement among policymakers and the profession on a better system.

John Kitzhaber, MD, former Governor of Oregon and Director of the Center for Evidence Based Policy at OHSU, spoke on the growing urgency of crises in health care system. In 2003 the cost of Medicaid has exceeded costs of education in most states. Now we are way past time for incremental reform. We need a revolution, not of violence, but of ideas.

GOVERNOR'S REPORT CONTINUED

Allocation of public resources is the contention to maximize health benefits. We need explicit entitlement, explicit public subsidy, all citizens contribute to a subsidy, all citizens are eligible, those citizens with more income can purchase additional services. Our current system has categorical eligibility. Medicare is an entitlement program, financed by taxes of those who are working. Medicaid is an entitlement program to improve financial access to poor citizens-poor children, blind and disabled, elderly in need of long term care. These programs have created a coverage gap (those who don't fit into categories) that now encompasses 45 million people. These individuals are forced to seek care in the ER, where the cost is shifted to outside sources. We need to view health care with the same view as public education. We need to demand a standard for public resources that benefits all and gives a defined benefit. The www.archimedesmovement.org will work with states to create waivers to be presented in congress to circumvent the current dysfunctional system.

Jock Murray, MD, MACP Professor Emeritus of Medicine at Dalhousie University in Halifax, Nova Scotia and former Chairman of the ACP Board of Regents spoke on what it is like to practice in a community with universal access to health care. He pointed out the differences between the US and Canada. In short he pointed out that Canada got it right by the: equality in the system, a value based system, placing controls over technology, non competition, controls over cost, minimal administration costs, macro management, resident training only in University Programs. What Canada got wrong is: inadequate research support, little target setting, and global cuts without planning, inaccurate planning of physician/nurse numbers.

In his opinion, he stated the US got it right on: protection of individual rights, innovation and creativity, research support, benefits to risk takers, and expertise in specialty medicine. The US got it wrong on: no coherent system, the uninsured and underinsured, an expensive and complicated administration, micro management, powerful competing forces, excessive specialty care, and inadequate support for primary care, no plan for when profit is gone, and finally malpractice issues. His summary slide was excellent in portraying the dilemma facing US health care system. "There are three choices and you can only pick two. Cover everyone, Do everything, and Get it right now." Compelling isn't it?

I welcome the opportunity to talk about any of the above or a topic important to you. You may contact me at AWinkler@sprg.mercy.net or 417-888-5664 or at the Missouri Chapter meeting September 28 - October 1 at the Lodge of Four Seasons.

2006 CHAPTER MEETING AND PROGRAM

The Missouri Chapter meeting will move to the Lodge of Four Seasons this year. The program, offering 18.75 hours of CME, begins Thursday evening, September 28 and concludes Sunday, October 1. In addition to the educational offerings, this year's meeting will honor an outstanding Chapter member as Laureate, three members will be recognized for Volunteer Awards, students for their Clerkship achievements, and Associate members competing in the Poster contest.

The scientific lectures will include updates on hypertension; chronic renal disease; NASH; lipids; hemotologic cases; rheumatology biologics; end of life care; and how women deal with heart disease to name a few.

Mark your calendar and watch our website - www.acp-missouri.org for complete details. Make your reservation now by calling 800-843-5253 (800-The-Lake).

SUPPORTING YOUR CHAPTER THROUGH CHAPTER DUES

Chapter dues are the backbone of local activities and vital to the success of our chapter. While we are provided some financial support from the national office, the chapter dues collected provide the majority of financial support for local activities. Educational meetings, mentoring programs for medical students, local Associates' research competitions, and participation by chapter leaders in Leadership Day on Capitol Hill are just some of the activities supported by your chapter dues. Many of these activities are orchestrated by unpaid volunteer leaders in our chapter. Your chapter dues help support the cost of local staff and provide funding for new and existing chapter initiatives. When you receive your dues notice, please remember to include the chapter dues in your payment. You will be contributing to the success of many grass roots activities happening right here at home.

MEDICARE URGES PHYSICIANS TO REGISTER INTENT FOR PHYSICIAN VOLUNTARY REPORTING PROGRAM

From CMS Kansas City Regional Administrator: Tom Lenz

In recent months, organizations including the Institute of Medicine, ACP, AAFP and the AMA have drawn attention to the importance of developing performance measures for physicians. In addition to these groups, major private health insurers have also turned an eye towards performance measures or pay for performance, unveiling new reimbursement programs for doctors that meet the insurer's standards of quality care and efficiency.

The Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, announced in October 2005 the launch of its Physician Voluntary Reporting Program (PVRP). The PVRP is a first step for reporting information on physician quality of care. At the end of December 2005, CMS announced a simplified core set of 16 performance measures for the program after receiving valuable feedback from national physician organizations; seven are primary care measures, two are for emergency physicians, two are for nephrologists, and five are for surgeons. Physicians were able to begin reporting quality data on the evidence-based measures in January 2006.

CMS is currently encouraging physicians to register their intent to participate in the PVRP through a secured link at <http://www.qualitynet.org/pvrpintent>. Physicians who register intent are not obligated to participate in the PVRP. On the flip side, physicians may submit data immediately on the PVRP measures without registering intent to participate.

In order to make reporting as straightforward as possible, the PVRP uses G-codes and CPT II codes on the Medicare claim form to pass data to CMS. Physician offices with electronic health records will also be able to participate in the PVRP through direct submission of clinical data.

The PVRP builds on CMS' successful implementation of reporting mechanisms for nursing homes, home health agencies and hospitals, with a goal of substantially improving the health and well-being of Medicare beneficiaries and others. Once the PVRP system is fully developed, it may be used to compensate physicians for the quality - rather than the quantity - of care they provide. Congress has made it clear that changes to the Medicare fee schedule formula will be linked with clinical performance reporting. The program currently is voluntary and is not yet tied to any payment. However, this is the direction in which health care appears to be moving.

Physicians who participate now:

- Will assess their own performance - The PVRP will provide information that will allow physicians to compare their performance with peers through confidential reports.
- Will ensure that both their claims processor and office software can support the reporting process.
- Will be able to provide feedback to CMS about the program.

In addition, the American Board of Internal Medicine (ABIM) and American College of Physicians announced on March 16, 2006 that ABIM will allow internists and subspecialists in internal medicine who are enrolled in ABIM's Maintenance of Certification program to use performance data provided through the PVRP to receive credit toward meeting ABIM's requirement for "self-assessment of practice performance."

For more on PVRP, including a complete listing of the PVRP quality measures and subspecialty worksheets, please visit <http://www.cms.hhs.gov/pvrp>.

MEDICARE PART B: CHANGE IS CONSTANT

- NPI (National Provider Identification number) is required for all Medicare providers by May 2007, however; it is mandatory for all new Medicare providers enrolling. You may also find non-Medicare plans using it too - www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp.
- The new Medicare Enrollment Applications (Form 855) are now available on the CMS website www.cms.hhs.gov/MedicareProviderSupEnroll.
- CMS has released its estimate for the 2007 conversion factor update (a reduction of 4.6%) - www.cms.hhs.gov/SustainableGRatesConFact/Downloads/MedPAC_Letter_Estimated_2007.pdf.
- Medicare Part B claims will be not be paid September 22-30 which will improve the government's fiscal year end cash position. The claims will be paid Monday, October 2 - www.cms.hhs.gov/Transmittals/Downloads/R847CP.pdf.
- Blue Cross Blue Shield of Kansas / Medicare Part B has announced all payments will be made once a week beginning June 7 - www.kansasmedicare.com/news_flash/2006/B_050106_PaymentsSentWeekly.htm.

MEDICAID PROVIDER HOT TIP OF THE WEEK

Missouri Medicaid processes six million claims monthly and the top two reasons for claims denial continue to be eligibility and duplicate claims. Further detail is provided on their website www.dss.missouri.gov/dms/providers/pages/provtips.htm about how your office can avoid unnecessary hassle by addressing these two issues.

GOVERNOR APPOINTS HEALTHCARE INFORMATION TECHNOLOGY TASK FORCE

Gov. Blunt issued an executive order in February to create the Missouri Healthcare Information Technology Task Force. The group is charged with reviewing the status of healthcare information technology adoption by the state, addressing issues related to the delivery of healthcare information, identifying private resources and public/private partnerships to fund efforts to adopt interoperable health information technology, exploring the use of telemedicine and making recommendations for implementation. **Julie Eckstein**, director of the Department of Health and Senior Services, will serve as chairperson of the group which includes four physicians.

MISSOURI SENDS FOUR TO ACP LEADERSHIP DAY

Four members of the Missouri Chapter participated in the ACP Leadership Day in Washington DC on May 16 and 17. Drs. **Sara Walker** of Columbia; **William Fogarty** of St Louis; **Sinhu Koshy** of Kansas City; and **Brent Beasley** of Kansas City met with the Missouri Congressional delegation after being briefed on the status of issues important to internists, including:

- The Medicare fee schedule,
- Building an electronic health information infrastructure,
- Professional liability reform and
- Access to care.

MISSOURI CHAPTER OF THE ACP
SCIENTIFIC PROGRAM AND SPECIAL EVENTS
UPDATES IN INTERNAL MEDICINE - 18.75 HOURS OF CME

Thursday, September 28, 2006

- Hypertension: Is JNC-VII out of date?
- Modern Challenges in End of Life Care

Friday, September 29, 2006

- Management of Chronic Renal Disease Prior to needing Dialysis
- New Treatments of Diabetes: Incretin System, Endocannabinoid and Inhaled Insulin
- Stump the Professor
- Medicare and Pay for Performance: Beyond Claims Data
- Humanities - On Being a Doctor
- NASH
- Interesting Hematologic Cases
- Lipids: Cardiovascular Risk Reduction
- Current Treatment Options for Epilepsy
- Prostate 2006: Evaluation and Management of Prostatic Disease

Saturday, September 30, 2006

- Interventional Management of Peripheral Vascular Disease (including Carotid)
- What Obstetricians Want Internists to Know
- Medicaid: How to Get Care for Your Patients
- Common Eye Problems - Update for Internists
- Chapter Business Meeting
- How Women Deal with Heart Disease
- What's That Chest X-ray?
- What's That Skin Lesion?

Sunday, October 1, 2006

- Sepsis
- Spinal Frontiers: Back Surgery and Interventions Update
- Fibromyalgia
- Helping Our Patients Quit Smoking
- Therapies with and Complications of Rheumatology Biologics

---VISIT OUR CHAPTER WEBSITE---

<http://www.acp-missouri.org/>

LAUREATE AWARD ANNOUNCED

Thomas J. Olsen, MD, FACP who practices general internal medicine at Saint Louis University School of Medicine has been selected to receive this year's Missouri Chapter of the ACP Laureate Award.



Dr Olsen has served on Committees and the Council of the Missouri Chapter for fifteen years, most recently as Treasurer of the Council. He received his Fellowship in 2000 and has been active in promoting others to Fellowship. The Missouri Chapter recognizes the significant contribution Dr Olsen has made to the Missouri Chapter. The Laureate Award will be given to Dr Olsen at the Awards Banquet during the Chapter meeting on Friday, September 29.

The Laureate Award, the Missouri Chapter's most prestigious award. It is designed to honor those Fellows and Masters of the College who have demonstrated, by their example and conduct, an abiding commitment to excellence in medical care, education, research, and service to their community, their chapter, and the College.

VOLUNTEER AWARDS

Also being recognized at the Awards Banquet will be a few of the many Missouri physicians who volunteer their time. This year those being honored include:

1. **Jonathan Jacobs, MD** of Kansas City for his work with displaced Katrina victims.
2. **Norm Knowlton, MD, FACP** of Springfield for 20+years of high school athletics service.
3. **Jerry Flance, MD, FACP** of St Louis for his work in the Forest Park - Southeast neighborhood.

The most difficult aspect of recognizing volunteers is the lack of information available on physicians who volunteer. Since none of our awardees self-nominates we need your assistance to recognize internists in your area who give their time generously.

CHAPTER EXCELLENCE AWARD WINNER

We are pleased to announce that our Chapter is in receipt of the 2005 Chapter Excellence Award. The Chapter Excellence Award recognizes those chapters that excel in reaching the standards for managing a chapter, such as communicating to members, instituting Medical Students' and Associates' activities and advancing and recruiting members. A Chapter Excellence certificate will be awarded to the chapter at the meeting by the College Representative.

MISSOURI CHAPTER BOOK AWARDS

The ACP Book award is presented at the medical school graduation ceremony to the graduating senior who meets the following criteria:

- (1) achieves the highest cumulative grades in all General Internal Medicine rotations and any required written examinations covering the general field of Internal Medicine in the third and fourth year of medical school;
- (2) has outstanding ethical and humanitarian qualities;
- (3) is committed to a career in General Internal Medicine or one of the subspecialties of Internal Medicine.

The award, named for a prominent internist at the school, consists of a certificate, a check in the amount of \$200 and a letter from the Governor of the Missouri Chapter. The following were recognized in 2006:

Bernadette A. Hiltner- Saint Louis University -
Coy D. Fitch, MD, MACP

David (Trey) James-University of Missouri - Columbia -
Charles S. Brooks, MD, FACP

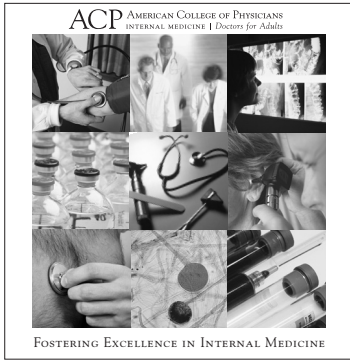
Adam Salisbury-University of Missouri - Kansas City -
Gary Salzman, MD, FACP

Andrew A. Lane-Washington University -
Michael M. Karl, MD, MACP

ACP

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Missouri Chapter Scientific Meeting
Lodge of Four Seasons
Osage Beach, MO
September 28- October 1, 2006

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