

Montana Chapter GOVERNOR'S NEWSLETTER

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

Summer 2005

Robert G. Byron, MD, MHP, FACP
Governor, Montana Chapter



GOVERNOR'S CORNER

Annual Session 2005 in San Francisco was a rousing success. **Derek Weiss** and **Steve Gerstner** were installed as new Fellows during Convocation. The Montana Chapter was well represented with about 10 attendees in total. San

Francisco, always a great city, was particularly cooperative this year with sunny skies all week.

For those who have not attended Annual Session in recent years, there are several changes. The ever popular Meet-the-Professor workshops were changed to include one ticketed session with smaller numbers, and, in most cases, a second session that is "un-ticketed," allowing more people to take part in these very practical sessions. There are considerably more hands-on sessions available at the Learning Center throughout the conference; everything from casting and splinting to physical exam tutorials on live patients to using computers and software in a practice setting. Online access was more available than ever at various stations throughout the convention center. For the first time this year, handouts were available online with stations for printing out those that you wanted, rather than trying to have them all printed ahead of time.

Now is a good time to start making plans for Annual Session 2006. It will be in **Philadelphia, April 6-8, 2006**. Register by July 29, 2005 and save \$50.

BOG REPORT

The spring Board of Governors'(BOG) meeting was held in conjunction with Annual Session. During the meeting emphasis was on the dysfunctional payment system with attention to strategies for improvements. This was approached by hearing about the payment system from the perspectives of the patient, the physician, and the payers separately. Then workshops were held to generate ideas

and methods for addressing the problems in ways that could be effective in actually making changes in a political and business environment.

During the meeting there was also a great deal of discussion related to pay-for-performance. These discussions were both part of the dysfunctional payment system deliberations, and separate, for their own sake. The College leaders have been and continue to be heavily involved in these trends. They are very attuned to our needs, as practicing physicians in varied practice settings.

There were a large number of resolutions on a wide variety of areas. They addressed all areas of internal medicine, from medical education to reimbursement to involvement in public health policy. Individual resolutions can be accessed through ACP Online by going to the following site: <http://www.acponline.org/private/resolutions/search.html>.

FALL MEETING

The Montana Chapter meeting will be held **Thursday through Saturday, September 15-17, 2005 in Butte**. Though the times are about the same as in the past, the format will change considerably. There will be fewer "lecture" style sessions, and more workshop type sessions that focus on specific topics in more depth.

Plans include incorporating an ABIM SEP module into the meeting. Final details are still being worked out. Participation in the SEP module will likely entail an additional fee for attendees based on ABIM requirements. Members can attend the rest of the meeting without being required to attend the SEP module portion.

You should receive a mailing with the details in the next few weeks if you have not already done so. Information will also be available on the Montana Chapter website at <http://www.acponline.org/chapters/mt/>.

CERTIFICATION UPDATE

Over the past year, a collaborative working relationship between the American College of Physicians (ACP) and the American Board of Internal Medicine (ABIM) has resulted in ABIM's granting credit for an attractive new option for ACP's Medical Knowledge Self-Assessment Program 13 (MKSAP 13) to fulfill part of the requirement for maintenance of certification. In addition, starting in January 2006, a modified overall framework for Maintenance of Certification will be instituted by the ABIM, motivated by a desire to increase flexibility, reduce redundancy, emphasize assessment of performance in practice, and simplify the process for physicians recertifying in both Internal Medicine and one or more of its subspecialties. This update of the Maintenance of Certification process will provide a summary of the following specific topics: 1) the new MKSAP option; 2) the modified ABIM framework for January 2006; and 3) reduction of anxiety for candidates taking the closed-book examination. Additional information about the new MKSAP option can be found on the ACP website, and further description of the new ABIM framework can be found on the ABIM website.

The New MKSAP Substitution Option

The MKSAP substitution option was designed to offer recertifying physicians an alternative method to the ABIM Self-Evaluation Process (SEP) modules for fulfilling the maintenance of certification requirement for self-assessment of medical knowledge. By using MKSAP, candidates can simultaneously fulfill this requirement while studying for the closed book examination. In addition, the MKSAP substitution option has been designed to incorporate immediate feedback as well as education (and links to educational resources) into the self-evaluation process.

How does the MKSAP substitution option work?

The MKSAP substitution option is available to MKSAP 13 subscribers (either print or CD-ROM subscribers) as a no-cost benefit. The entire process is completed electronically. Candidates use their MKSAP subscriber privileges to access up to four question modules via the Internet, download them to their computer, answer the MKSAP question sets, and, using their ABIM candidate number, submit their responses via the Internet for ABIM recertification credit. MKSAP 13 subscribers who have registered with ABIM for maintenance of certification can initiate the process by accessing the following: <http://www.acponline.org/mksaprecert/>

Each question is presented in a way that combines self-assessment with education, and provides immediate feedback to the candidate. After the candidate reads the question, (s)he first selects and enters an answer choice for "grading" by the computer. If the submitted answer is correct, the candidate receives immediate feedback from the computer that the answer is correct, and is presented with the critique and discussion of the question. There is also an opportunity to link immediately to the relevant text from MKSAP 13 in order to obtain further educational material relevant to the question.

If the candidate answers the question incorrectly, (s)he receives that feedback immediately from the computer, and is provided with the link to the relevant MKSAP 13 text. After reading the text, the candidate has a second opportunity to answer the question. Following the second answer, the candidate receives immediate feedback about whether the answer is correct, and is presented with the critique and discussion of the question. Candidates are not required to complete each set of 60 questions at a single sitting, but can do so at whatever schedule is convenient for the candidate.

Following completion of each 60 question module, the candidate receives two scores: a) a score based on the first answer provided for each question; b) a score based on the second answer provided for each question. Because each of the questions has been pre-tested, candidates are provided feedback about how their score compares with the scores of others who have pre-tested the examination. This information is useful to the candidate in allowing him/her to identify areas for further study in preparation for the closed book, secure examination.

Although candidates immediately receive scores based on their completion of the questions, all candidates who complete the MKSAP question sets receive the appropriate amount of maintenance of certification credit (the equivalent of 1 module of credit for each set of 60 questions). Thus, there is no threshold score that one must obtain before receiving credit. The ACP is responsible for processing the information related to completion of the MKSAP questions, and for providing ABIM with the name of each candidate who has completed the MKSAP questions for credit.

The Modified ABIM Framework

Starting January 2006, the previous requirement for completion of five ABIM SEP modules will evolve into a "point system" requirement that incorporates flexible options for self-assessment of knowledge and practice

performance. Each candidate will need to complete 100 self-evaluation points as part of the maintenance of certification process. The same points are applicable to all certificates and are valid for 10 years (i.e. extra points are not needed if a candidate is applying for both internal medicine and a subspecialty within the 10 year period during which the points are valid). The required 100 points are divided in the following way: a minimum of 20 points must relate to self-evaluation of medical knowledge; a minimum of 20 points must relate to self-evaluation of practice performance; and 60 points are elective and can relate to either category of self-evaluation. Each ABIM SEP module counts as 20 points relating to self-assessment of medical knowledge, as does each MKSAP question module.

How Do I Get Credit for Self-Evaluation of Practice?

A variety of options will be available for fulfilling the 20 point minimum requirement for self-evaluation of practice, and the number of points given for each option will depend upon the amount of work involved. There are three basic components to this self-evaluation of practice: 1) measuring practice performance from data that the physician collects or receives from another source; 2) developing and implementing a plan for improvement; and 3) assessing the impact of the improvement plan. The types of options that will be available for assessing practice performance include: 1) ABIM Practice Improvement Modules (PIMs); 2) ABIM survey modules (Peer, Patient, and Practice Inventory); 3) established quality measurement and improvement programs; and 4) self-directed quality measurement and improvement. Credit for performance assessment is given with completion of one of these options; there is no grade given and thus no "passing" score. The ABIM's PIMs will count as 40 points and the survey modules will count as 20 points. The ABIM will assign points to new modules as well as tools and programs developed by others according to pre-established standards and criteria.

What is Happening During the Transition Period Before January 2006

The new point system framework (and the need to include self-evaluation of practice) will not apply to physicians who complete the current self-evaluation module requirement (including the option for substituting up to 4 modules of MKSAP) before January 2006. If a physician still has one or more SEP modules to complete after January 2006, then the new guidelines will be in effect, and 20 Practice Evaluation points will be needed to complete the Self-Evaluation process.

Reducing Anxiety About the Secure Examination

Although a closed book examination can elicit anxiety, a better understanding of the examination and the types of questions on the examination can help allay that anxiety. As a result, the ABIM is committed to increasing communication about the examination to recertification candidates, and to clarifying what are sometimes misconceptions about the examination.

An important point of clarification is that the maintenance of certification examination is different from the examination used for certification of residents who have recently completed housestaff training. Residents typically are exposed to specialized types of inpatient problems that are primarily handled by subspecialists, and are therefore not part of the "core" practice or experiences that cut across general internal medicine as well as most subspecialties. Therefore, the maintenance of certification examination focuses on topics that are relevant and of clinical importance to all internists. At the same time, the maintenance of certification examination questions are designed to test clinical judgment, not recall of obscure facts. A Board-certified clinician should be able to answer these questions without using additional resources, since the questions are testing judgment rather than factual recall.

The pass rate for the examination is generally approximately 89 percent on the first try, whereas approximately 97 percent of candidates ultimately pass the maintenance of certification examination. The passing score is set as an absolute threshold, and is not based on a curve. Thus, there is no intent to fail a specified percentage of candidates taking the examination.

Perspective About the Recent Collaboration Between ACP and ABIM

Over the past year, ABIM has clearly demonstrated a commitment to a collaborative, cooperative working relationship with ACP. ABIM is also committed to ongoing improvement in the process for maintenance of certification, with specific goals of reducing redundancy and adapting the program for relevance and usefulness in the practice environment. And finally, ABIM and ACP are both committed to continuing to work together for the best interests of our physicians, our patients, and the discipline of internal medicine.

DIABETES REMINDER

Diabetes is an epidemic. There are an estimated 5.2 million Americans of all ethnicities with diabetes who have not yet been diagnosed. In American Indians in Montana, the number of adults reporting a diagnosis of diabetes increased from 12% to 16% between 1999 and 2003, according the Jan-March 2005 issue of the Montana Clinical Communication Surveillance Report, numbers which agree with those from different sources from the Indian Health Service.

While most Internists are aware of the treatment goals, many different studies have shown that overall, patients are not meeting those goals, whether related to glucose levels, blood pressure control, lipid goals, or others. One approach to help us as physicians help our patients better manage their diabetes is to reduce the information to basic, manageable ideas:

1)Reducing blood glucose and HbA1c levels reduces the risk of diabetic complications. Intensive therapy has been shown to be superior to conventional therapy in terms of reducing glycemia and diabetic complications. 2)When monotherapy with an oral agent is no longer adequate, combination therapy with 2 or more oral agents has been shown to significantly improve glycemic control. 3)When oral monotherapy or combination oral therapy is no longer adequate, insulin can be added to the regimen to significantly improve glycemic control. 4)Benefits of insulin therapy, such as improved outcomes and glycemic control, outweigh risks such as the potential for inducing hypoglycemia. 5)Type 2 Diabetes mellitus is a disease consisting of two components: insulin resistance and insulin deficiency.

Though simplistic, these ideas can lead to more effective treatment of the myriad problems associated with diabetes management. We often lose the forest (overall management) in the trees (individual medications or management options).

The College and the American College of Physicians Foundation have begun a 3-year initiative to improve diabetes care. In addition to a diabetes track of sessions introduced at Annual Session 2005, this will include consolidating information about diabetes in a single web portal. That will bring together information from PIER, MKSAP, as well as the latest research data related to diabetes. Specific clinical decision support and CME will be parts of the web portal.

Information will be available at ACP Online

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, advocacy with state legislators, 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. However, the increase in activities at the local level has created the need for additional staff support to help manage the day to day operation of the 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.

TIDBITS

- Do you know a colleague who is not a member of ACP? Recruit new members and get your own dues paid. For details go to http://www.acponline.org/college/misc/recruit_colleague.htm?hp
- Online dues payment is now available. This year you will receive a separate mailing, even if you do pay online. Starting in 2006, those who pay online will not receive a separate mailing, thereby cutting costs and intrusions.
- Ready for advancement to Fellow? Contact either ACP headquarters or Paula Slyker at 406-638-3309. The actual application process has been streamlined compared to the past.

If you have questions I am glad to discuss them with you, just call or contact me at one of the addresses below:

E-mail: rgbyron@starband.net

Phone: (H) 406-665-3038

(W) 406-638-3300

—VISIT OUR CHAPTER WEB SITE—

<http://www.acponline.org/chapters/mt>

GOVERNORS TACKLE FLAWED PAYMENT SYSTEM ANNUAL SESSION DAILY

APRIL 14, 2005 *By Janet Colwell*

No payment for coordinating care. Claims that take three months to process. No incentives to invest in information technology.

These are just a few of the symptoms that the Board of Governors noted about the dysfunctional payment system. That issue topped the Board of Governors meeting agenda earlier this week as Governors, Regents and invited speakers met to discuss the flawed reimbursement system and ways to reform it.

The dysfunctional payment system is a reflection of deeply held cultural values, observed **Glenn M. Hackbarth, JD**, former chief executive officer of Harvard Vanguard Medical Associates and current chair of the Medicare Payment Advisory Committee (MedPAC), one of the speakers who addressed the Governors. Those values include the idea that clinician autonomy is more important than accountability and that all possible interventions must be done, regardless of cost.

There is also a widespread belief in this country that medicine and science can triumph over any illness or disability, he added. That belief drives higher spending on health care—often to the detriment of education, the environment and other important areas. As several of the Governors pointed out, these beliefs also adversely affect the way physicians are paid.

Three perspectives

In a series of workshops in which Mr. Hackbarth and other speakers participated, the Governors looked at the issue from the perspective of physicians, payers and patients.

"The dysfunctional payment system is oppressive, Byzantine and discriminatory," said **Cecil B. Wilson, MACP**, who led the discussion from the physician's perspective. Dr. Wilson, who has a solo practice in Winter Park, Fla., said he has more than 1,300 insurer addresses in his computer and that three-to-four month payment delays are common whenever a patient switches plans.

Patients often expect their physicians to know the details of all of these plans, he added, while insurers expect doctors to be 100% accurate in their filings or face payment delays. Fear of denied or delayed payments, he added, encourages physicians to adopt tactics such as downcoding to avoid denials.

Dr. Wilson listed other problems of the flawed payment system from physicians' point of view; those include administrative hassles and poor communication between physicians and insurers.

From patients' vantage point, the flawed payment system doesn't work either, said MedPAC's Mr. Hackbarth. Patients' concerns include coverage availability, affordability, administrative complexity and a fragmented system that rewards complex, technological solutions over quality of care.

A third speaker, **Reed V. Tuckson, MD**, senior vice president of consumer health and medical care advancement at UnitedHealth Group, provided the payers' perspective. While

payers want to work with physicians, he said, they are facing relentless pressure from big employers, who are "terrified" about how rising health care costs are affecting their bottom line. At the same time, he said, consumer and quality groups continuously point to credible studies on medical errors and the gap between cost and quality.

UnitedHealth has taken steps to improve communication with physicians, said Dr. Tuckson. For example, it has introduced an insurance card that can be swiped in any card-reading terminal, giving physicians instant access to a patient's benefits and eligibility information. Soon, he said, that information will be merged with payment information.

The company is also trying to align its reimbursement policies with Medicare whenever possible, Dr. Tuckson said. "The goal is to achieve consistency so there is less confusion."

Sellable solutions?

The Governors discussed the idea of the primary care physician's office as the patient's "medical home," with the internist acting as care coordinator and being reimbursed accordingly. Dr. Tuckson said health plans are interested in the idea, but must first see proof that such a system would reduce costs.

Several Governors also suggested changes to the insurance industry, including standardizing benefits across plans and mandating individual coverage. By simplifying communication among insurers, doctors and patients, the Governors said, additional savings would be realized. Selecting an insurance plan should be more like buying a car, allowing consumers to select from a standard menu of options, said Board of Governors **Chair Frederick E. Turton, FACP**, in his summary of the workshop sessions.

According to Mr. Hackbarth, pay-for-performance programs could hold some answers by rewarding doctors for efficiently using technology and for following evidence-based guidelines.

"Now we are rewarding more care and advanced care instead of quality or right care," Mr. Hackbarth said. "The current payment system discourages doctors from trying to think of innovative ways to meet patient needs."

The Board of Governors also approved a number of resolutions related to reimbursement that will be considered by the Board of Regents. Those resolutions included:

Funding pay-for-performance rewards with new dollars created from cost savings, separate from inflationary updates in physician fee schedules.

Increasing compensation for cognitive services by exploring changes to the current payment system. Suggested changes included changing the Medicare formula of tying fee increases to the sustainable growth rate and revising the fee-for-service-based payment methodology, which is based on acute episodic care.

Working with the AMA to advocate for an increase in physician fees for visits to Medicare beneficiaries in nursing homes.

IMPORTANT DATES

**MONTANA CHAPTER
ACP SCIENTIFIC MEETING,
BUTTE, SEPTEMBER 15-17, 2006.**

**ANNUAL SESSION,
PHILADELPHIA
APRIL 6-8, 2006.**

**REGISTER BY JULY 29, 2005
AND SAVE \$50.**

CONTACT INFORMATION

Robert Byron, MD, MPH, FACP

Governor, Montana Chapter ACP

Route 1, Box 1079

Hardin, MT 59034

Phone: (H) 406-665-3038

(W) 406-638-3300

(Cell) 406-679-0584

E-mail: rgbyron@starband.net

Paula Slyker, Medical Staff Assistant

Crow/Northern Cheyenne IHS Hospital

Crow Agency, MT 59022

Phone: 406-638-3309

E-mail: Paula.Slyker@ihs.gov