

Nevada Chapter GOVERNOR'S NEWSLETTER

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

Spring 2005

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NOTES FROM THE SPRING BOARD OF GOVERNORS MEETING



Jim Christensen

The “dysfunctional payment system” was profiled from three different perspectives--the physician, the patient, and the payer. This topic is responsible for almost everything we don't like about the practice of medicine. Yet it remains one of the greatest challenges/opportunities for future generations of physicians.

The Physician perspective, presented by **Cecil Wilson, MD, MACP**, (Winter Park, Florida) highlighted the challenges of the solo practice internist. His practice consists of 5000 patients, one third of which have straight Medicare, yet two thirds of all his encounters are Medicare visits. He employs 4 support personnel and shares expenses and lab with another solo internist. It requires 90 minutes of time to reconcile 12 patient encounters from a Medicare EOB; this does not include the time spent up front with data entry and verifying benefits. His patients assume the doctor's office knows what is covered and what isn't and they expect the staff to do all prior authorizations. He has 1300 addresses for insurance companies in his billing program and only 3 ways of paying (cash, check, or credit cards). Dr. Wilson noted that physicians are the only sector of the work force that 100% accuracy is required in order to get paid for services rendered. He also noted that patient's continuity of care is compromised because employers switch health plans regularly to keep their costs down. Medicare is the defacto payment standard and usually represents the ceiling not the floor in terms of reimbursement. Physicians now face automatic cuts of 4 to 5 % in Medicare reimbursement over the next 7 to 8 years and are the only sector of the work force whose reimbursement is tied to the sustainable growth rate of the US economy. Don't look to other groups to help us in this political fight.

The payer's perspective presented by **Glen M Hackbarth, JD**, Chairman of MedPAC (Medicare Advisory Commission) outlined the consumers' seven complaints about the health care system. They are as follows: availability, affordability, complexity of the system, fragmentation of the system, too many choices and too little choices, no reward for quality, and retardation of innovation in care delivery systems. Currently 45 million Americans lack health insurance and the number of uninsured is increasing. Financial gains from treatment of heart disease and low birth weight infants out weigh the total costs of the system, yet the benefits could be greater. We need to improve quality, but currently buying power is fragmented by the complex system and we ultimately pay higher prices. Look at prescription drugs prices; their increase outpaces the increase in salaries. Currently, we have few choices in buying health care with little economic feedback to the system. Employers try to herd employees into managed care to save money. An example of too much choice in our health care system is the new Medicare drug benefit. These benefits will be administered by private plans that will use closed formularies and will be subject to constant change depending on deals cut with the pharmaceutical industry and pharmacy benefits managers. Currently, the reimbursement system rewards more care and more technology not evidence based appropriate care.

The Payer's Perspective presented, by **Reed V. Tuckson** M.D. SVP Consumer Health and Medical Care at United Health Group. According to United Health, they have an intimate relationship with the patient but they respect the centrality of the patient-physician relationship. "Everybody is hurting (under stress) and there can be no meaningful change without a productive dialogue between physician and health plans." United Health views the market as being driven by five different forces for change: the cost escalation for employers, affordability is an increasing problem for consumers, variation from best scientific evidence (30% of all direct health care costs are due to poor care), rapidly expanding new knowledge, drugs and technology, a consumptive society (everybody wants everything done), and the population is aging with more chronic illness. Detailing as performed by the pharmaceutical industry is 60% spin for their financial gain, the inappropriate use of cox-2 inhibitors cost the US consumer approximately 6 billion dollars. According to Reed Tuckson, MD everything starts as a continuous recommitment to values of Professionalism. United Health wants to remove hassles of practice administration (reimbursement). They promise to be our friends - RIGHT! We have all heard this before but they are making real advances with electronic medical records.

Also approved at the Board of Governors meeting were a number of resolutions for consideration by the Board of Regents. Some of those resolutions included:

- Funding pay for performance rewards created by cost savings, separate from inflationary updates in physician fee schedules.
- Working with the AMA to increase the reimbursement to physicians making nursing home visits.
- Increasing the compensation for cognitive services rendered by internists by exploring changes in the payment system. Suggested changes involved changing the Medicare formula for calculating fees which are tied to the sustainable growth rate.

The next meeting for the Nevada Chapter will be on January 14, 2006 in Las Vegas. It will either be at the Four Seasons or the Wynn Resort. Currently the ACP membership captures 43% of the market of internists-72% are in clinical practice (46% in private practice). These numbers along with a strong lobbying presence in Washington will turn into clout, but with more numbers comes greater strength. Maintain your membership and refer your colleagues, together we can make a difference.

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.

UPDATE ON MAINTENANCE OF CERTIFICATION APRIL 2005

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.



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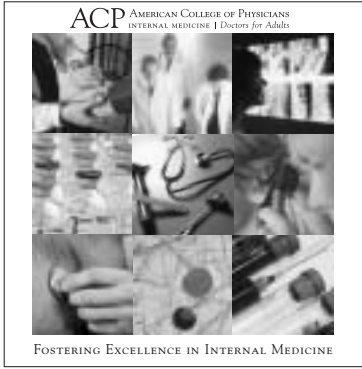


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