Internal Medicine: Reflections on the Past and Look to the Future

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Disclosures

- I am an employee of the American College of Physicians (ACP)
- I have no financial relationships with pharmaceutical companies, device manufacturers, etc.

Origin of the term “Internal Medicine”

- Friedrich Theodor von Frerichs (1819-1885)
- April 20, 1882, Wiesbaden: 1st "Congress für innere Medicin"
- Term imported by physicians trained in Germany
Sir William Osler: “Father of Internal Medicine”

1st edition: 1892

Who are internal medicine physicians?
ACP’s definition (2013)

"Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness."

Internal medicine has the richest diversity of professional activities

<table>
<thead>
<tr>
<th>Domain</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional role</td>
<td>Primary care clinician</td>
<td>Consultant</td>
</tr>
<tr>
<td>Area of expertise</td>
<td>General internal medicine</td>
<td>Subspecialty</td>
</tr>
<tr>
<td>Structure of practice</td>
<td>Solo practice</td>
<td>Large multispecialty group</td>
</tr>
<tr>
<td>Professional emphasis</td>
<td>Clinical practice</td>
<td>Teaching, research, administration</td>
</tr>
<tr>
<td>Work setting</td>
<td>Outpatient</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>
But this diversity also has led to some tensions and questions

- How closely should internal medicine be aligned with “primary care” vs. “consultative medicine”?
- Is “general internal medicine” the same as “primary care”?
- Is there a “core” of internal medicine knowledge and skills that all subspecialists should maintain throughout their career?
- Should internists differentiate into outpatient and inpatient physicians, or should they be maintaining knowledge and skills for both settings?

The top 5 “hot issues”

- Workforce
- Payment for quality
- Controlling healthcare costs
- Future of the Affordable Care Act
- Delivery of patient-centered care
2016 AAMC projections: physician supply and demand through 2025

- Physician demand ↑ 17%: mostly growth/aging of population; also ACA-related needs
- By 2025, overall physician demand > supply: 61,700-94,700. Specific shortfalls:
  - 14,900-35,600 primary care physicians
  - 3600-10,200 medical specialists
  - 25,200 to 33,200 surgeons and surgical specialists


Figure 1
Percent of Population Residing in Primary Care Health Professional Shortage Areas (HPSAs), 2014

PGY-1 matches by students to categorical internal medicine programs: 2016

Source: NRMP 2016 Residency Match Data
Career choices of PGY-3 residents

Source: Internal Medicine In-Training Exam

Internal medicine subspecialty fellowship match: % positions matched 2011-2016

Source: NRMP 2016 Specialty Match Data

Selected ACP activities re workforce

- Recent policy paper on GME funding: early online publication in *Annals of Internal Medicine* May 3, 2016
- Support of internal medicine interest groups
- Advocacy efforts
  - All-payer funding of GME
  - Support of legislation to address shortage of resident positions in key areas of workforce shortage
  - Promotion of team-based care
This move toward team-based care requires fresh thinking about clinical leadership and responsibilities to ensure that the unique skills of each clinician are used to provide the best care for the patient as the patient's needs dictate, while the team as a whole must work together to ensure that all aspects of a patient's care are coordinated for the benefit of the patient.

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Quality Payment Program in a nutshell

Law intended to align physician payment with value

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Or now the...
- Quality Payment Program
- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)
This new MIPS “report card” will replace current Medicare reporting programs

There are currently multiple individual quality and value programs for Medicare physicians and practitioners:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier (quality and cost of care)
- “Meaningful use” of EHRs

MACRA streamlines those programs into MIPS:

Merit-Based Incentive Payment System (MIPS)


How will clinicians be scored under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Advancing Care Information</th>
<th>Clinical practice improvement activities</th>
<th>Cost</th>
<th>MIPS Composite Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>50%</td>
<td>25%</td>
<td>15%</td>
<td>10%</td>
<td>[60% until 2018]</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>25%</td>
<td>15%</td>
<td>10%</td>
<td>[Starting in 2018]</td>
</tr>
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How much can MIPS adjust payments?

- Based on the MIPS composite performance score, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are budget neutral.

Adjustment to provider’s base rate of Medicare Part B payment

- 2019: -4% (Top 25% eligible for an additional annual performance adjustment of up to 10%)
- 2020: -5%
- 2021: -7%
- 2022 onward: -9%

### Advanced APMs

- Eligibility: 25% of Medicare covered services or 20% of Medicare patients through Advanced APM (percentages increase in 2019)
- Specific Advanced APMs in 2017
  - Comprehensive Primary Care Plus (CPC+)
  - Medicare Shared Savings Program ACOs
  - Next Generation ACO Model
  - Oncology Care Model (OCM)
  - Comprehensive ESRD Care Models
- Models include EHR use, quality measures

### Timeline and payment changes

- Data collection for MIPS in 2017 affects payment in 2019
  - Don’t submit data ⇒ -4% payment adjustment
  - Submit data minimum ⇒ no payment adjustment
  - Submit 90 days data ⇒ neutral or small positive (or negative) adjustment
  - Submit full year data ⇒ moderate positive (or negative) adjustment
- Advanced APM participation in 2017 ⇒ can get 5% incentive payment in 2019

### Selected ACP activities re QPP

- Frequent feedback to CMS regarding proposed regulations relating to QPP, focusing on reducing clinician burden and integrating quality measurement with care delivery
- Providing input re performance measure development
- Education to increase awareness of QPP
- Development of variety of resources to help practices meet changing requirements, e.g., ACP Practice Advisor, deadline text alerts
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Mandate to reduce the cost of care

![Graph showing % US GDP from 1965 to 2020]

CMS, Office of the Actuary, National Health Statistics Group

OECD countries allocated 8.9% of their GDP to health in 2013 (excluding investments), ranging from over 16% in the United States to 5-6% in Turkey, Estonia and Mexico

Health expenditure as a share of GDP, 2013 (or nearest year)

Note: Excluding investments unless otherwise stated.
1. Data refers to 2012
2. Including investments

Source: OECD Health Statistics 2015, OECD, WHO Global Health Expenditure Database.
Excess cost domain estimates

From Reinhardt blog, NY Times, 12/24/2010

Source: ACP Internist (J.C. Duffy, B. Montgomery)
Academia and the Profession

Teaching High-Value, Cost-Conscious Care to Residents: The Alliance for Academic Internal Medicine–American College of Physicians Curriculum

Carlos T. Smith, MD, on behalf of the Alliance for Academic Internal Medicine–American College of Physicians High-Value, Cost-Conscious Care Curriculum Development Committee

Health care expenditures are projected to reach nearly 35% of the U.S. gross domestic product by 2030 up to $3.5 trillion if the spending has been identified as potentially avoidable, many of the avoidable expenditures have been identified. Effective strategies to measure, monitor, and improve quality of care in a sustainable manner have historically involved little specific training in the evaluation of health care cost, outcomes, and methods of cost analysis. This article describes a new curriculum that was developed collaboratively for residents in internal medicine and launched in 2011 by the American College of Physicians to address the training gap. The curriculum introduces a simple, heuristic framework for delivering high-value care and focuses on teaching trainees to incorporate high-value, cost-conscious care principles into their clinical practice. It consists of an hour-long, core, interactive session designed to be repeated during the course of training. The training is delivered in a mandatory, preconference design of the incoming training program.


Ideas and Opinions

Providing High-Value, Cost-Conscious Care: A Critical Seventh General Competency for Physicians

David A. Wendling, MD

There is general agreement that the U.S. economy cannot sustain the staggering economic burden imposed by the current and projected costs of health care. Various governmental approaches are being considered to address this issue, but the responsibility of the medical profession to become cost-conscious and demonstrate economic value that does not benefit patients but represents a substantial portion of health care costs. At present, the General Competency for Cost-Consciousness (CC) is taking shape as a new addition to the ACGME Common Program Requirements (CPR) as a seventh general competency. The competency requires that the medical profession develop a comprehensive approach to managing health care costs, including quality, access, outcomes, and ethical issues. The seventh general competency will help physicians better understand the need for effective use of resources and the importance of cost-effectiveness in the delivery of care. The competency will also help physicians improve their ability to communicate with patients and families about the costs of medical care and the importance of cost-effectiveness in the delivery of care. The competency will be assessed through a combination of self-assessment and peer review, with an emphasis on the ability of physicians to demonstrate their ability to improve the cost-effectiveness of their care.
ACGME milestone relating to stewardship of resources

Selected ACP activities re healthcare costs

The top 5 “hot issues”
President Trump’s comments to Congress (February 28, 2017)

“I am also calling on this Congress to repeal and replace Obamacare --- with reforms that expand choice, increase access, lower costs, and at the same time, provide better healthcare. Mandating every American to buy government-approved health insurance was never the right solution for our country. The way to make health insurance available to everyone is to lower the cost of health insurance, and that is what we are going to do.”

But, the GOP is finding that . . .

- Replacing the ACA with “something” that does not cause tens of millions to lose coverage is nearly impossible.
- Repeal and delay could cause insurers to exit the markets later in 2017.
- There is no GOP consensus on what should replace it—HSAs, selling insurance across state lines, age-based tax credits, Medicaid block grants are on their wish list, but all would likely erode coverage compared to ACA.
- Voters are besieging GOP lawmakers not to take their coverage away.

CDC: Uninsured rate has fallen below 9%
What’s at stake?

- Full ACA repeal could result in 59 million losing coverage
  [http://www.urban.org/research/publication/implications‐partial‐repeal‐aca‐through‐reconciliation](http://www.urban.org/research/publication/implications‐partial‐repeal‐aca‐through‐reconciliation)

- Reversing historic gains in coverage
  - 1 out of 4 Americans, 52 million, have a pre-existing medical condition that was “declinable” before the ACA [http://kff.org/health‐reform/issue‐brief/pre‐existing‐conditions‐and‐medical‐underwriting‐in‐the‐individual‐insurance‐market‐prior‐to‐the‐aca/](http://kff.org/health‐reform/issue‐brief/pre‐existing‐conditions‐and‐medical‐underwriting‐in‐the‐individual‐insurance‐market‐prior‐to‐the‐aca/)

What’s at stake?

- More than 20 million covered by Medicaid expansion or ACA subsidized plans could lose coverage

- Medicaid is the largest public insurance program in the United States, with more than 70 million enrolled; “block grants’ or per capita caps could result in millions of them losing coverage or benefits

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>AIDS/HIV</td>
<td>Smoker</td>
</tr>
<tr>
<td>Alcohol abuse/habitual use of drugs</td>
<td>Mental disorders (e.g., bipolar, eating disorders)</td>
</tr>
<tr>
<td>Diabetes/Mellitus</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease</td>
<td>Muscular dystrophy</td>
</tr>
<tr>
<td>Cancer within five years of claim (e.g. breast, colon, lung, other)</td>
<td>Obesity, asthma</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Polyphagia</td>
</tr>
<tr>
<td>Chronic lung disease, chronic kidney disease, liver disease, or cancer</td>
<td>Pernicious anemia</td>
</tr>
<tr>
<td>Chronic respiratory disease (COPD/emphysema)</td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD/emphysema)</td>
<td>Fracture surgery or hip replacement</td>
</tr>
<tr>
<td>Diabetic retinopathy</td>
<td>Neurogenic peripheral neuropathy</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>Pregnancy or previous parent</td>
</tr>
<tr>
<td>Hereditarylijk</td>
<td>Sickle cell</td>
</tr>
<tr>
<td>Hepatitis B/C/D</td>
<td>Sickle cell trait</td>
</tr>
<tr>
<td>History of heart failure</td>
<td>Transfusion</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
How do primary care physicians feel?

### Primary Care Physician Support for ACA Repeal

<table>
<thead>
<tr>
<th>Support</th>
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</thead>
<tbody>
<tr>
<td>Republican 32%</td>
</tr>
<tr>
<td>Democrat 0%</td>
</tr>
<tr>
<td>Overall 15%</td>
</tr>
<tr>
<td>Trump Voters 30%</td>
</tr>
<tr>
<td>Clinton Voters 0%</td>
</tr>
</tbody>
</table>

**Source:** N Engl J Med 2017;376, e8

What is ACP doing about coverage, access and the ACA?

- Urged "no" vote on budget resolution to start process of repeal
- Gave Congress recommended priorities for coverage and consumer protections
- Developed 10 questions to evaluate impact of any legislation to improve or replace the ACA
- Formed a coalition with AAFP, AAP, ACOG, and AOA—collectively represent 500,000 physicians and medical student members, developed joint principles, leaders met with Senators on 2/2
- Joint ACP, AAP, ACOG letter to President Trump on 2/28 urging "do no harm" to essential coverage and protections
- ACP letter to congressional leadership on 3/1 providing specific input on possible "replacement" options
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Focus on patient-centered care

The patient-centered medical home (PCMH) provides care that is team-based and:

- Patient-centered – partnership among patients, families, and providers
- Comprehensive – wholly accountable for physical and mental health care needs
- Coordinated – across all elements of healthcare system
- Accessible – shorter waiting times, after hours care, electronic or telephone access
- Committed to quality and safety – embracing quality improvement

Patient-centered medical neighborhood

- Includes broader healthcare community interacting with patients, families, and PCMH
- Importance of coordinating care across primary care clinician, consultants, and other healthcare providers
- Bidirectional communication
  - Explicit understanding of expectations of care
  - Coordination across care settings – outpatient, inpatient, rehab, assisted care/nursing home
- Importance of EHR interoperability
Care as a partnership between patients and clinicians

- Must be expressed at different levels
  - Micro level: patient-clinician partnership
  - Macro level: patient voice in improving care delivery by practices/systems

- Examples of initiatives
  - ACP’s Center for Patient Partnership in Healthcare
  - OpenNotes
  - Patient advisory councils
  - Patient-centered medical education

OpenNotes: a patient-centered electronic medical record

OpenNotes: a patient-centered electronic medical record

Partnering with patients in medical education

- Routine incorporation of patient’s perspective, goals, preferences, e.g., in notes
- Change rounds from disease focus to patient focus
- Patients as teachers – understanding patient experience of care
- Patients as evaluators of care provided by trainees

Source: Ann Intern Med. 2014; 161:73-75
### Selected ACP activities re patient centeredness

- Promotion of patient-centered medical home (PCMH) as a model of care
- Development of Center for Patient Partnership in Healthcare
- Collaboration with patient/consumer organizations, e.g., National Partnership for Women and Families, Institute for Patient- and Family-Centered Care
- Opportunities in the training environment

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