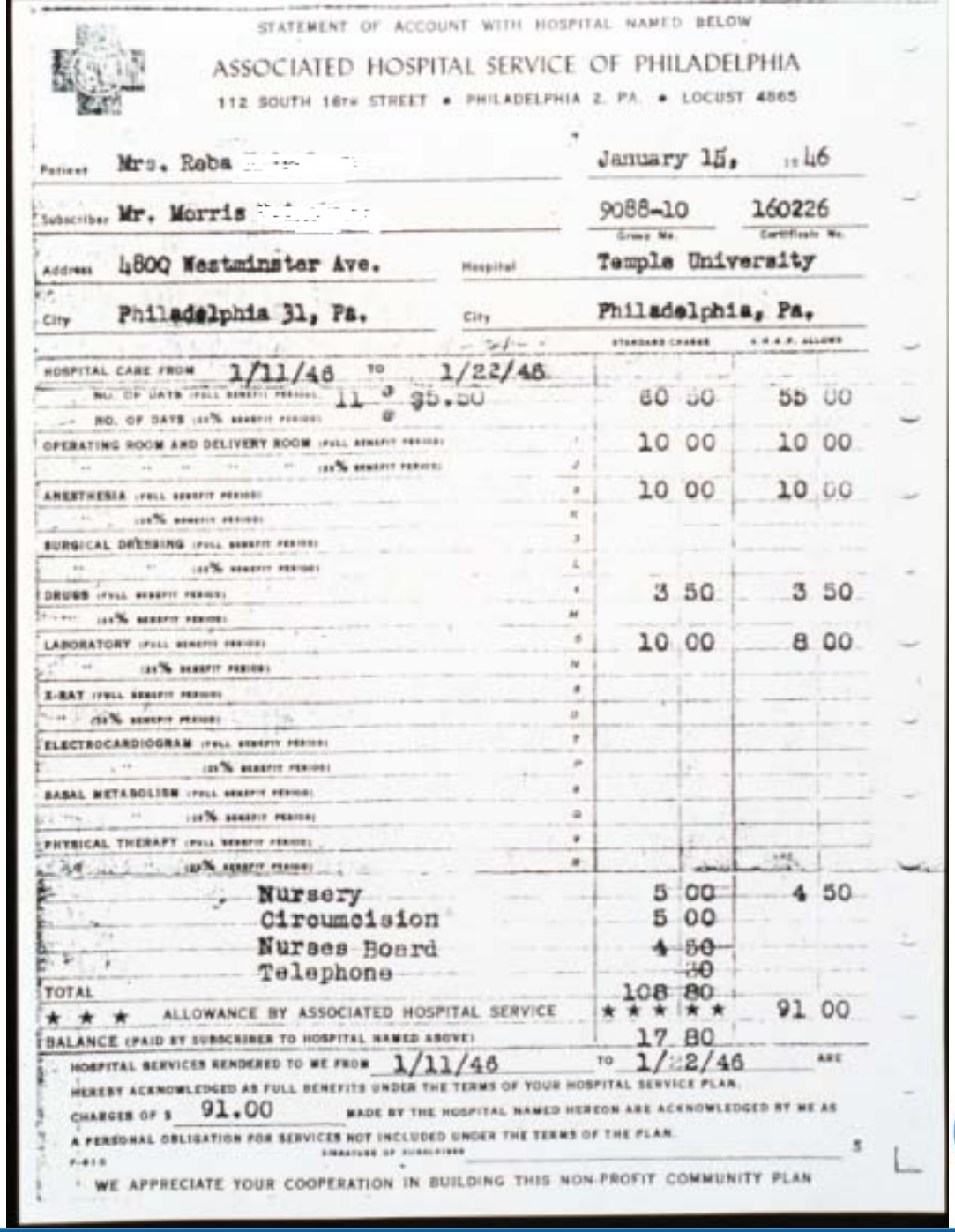
American Board of Internal Medicine

Getting the Idea: Activating medical professionalism for high value care

Medicare and Medicaid: The Next 50 Years
National Academy of Social Insurance
Washington, DC
January 28, 2015

Richard J. Baron, MD, MACP
President and Chief Executive Officer
American Board of Internal Medicine and ABIM Foundation

Bill for the delivery of a healthy baby boy in 1946



STATEMENT OF ACCOUNT WITH HOSPITAL NAMED BELOW

ASSOCIATED HOSPITAL SERVICE OF PHILADELPHIA

112 SOUTH 16th STREET • PHILADELPHIA 2, PA. • LOCUST 4865

Patient Mrs. Reba [redacted] January 15, 1946

Subscriber Mr. Morris [redacted] 9088-10 (Group No.) 160226 (Certificate No.)

Address 4800 Westminster Ave. Hospital Temple University

City Philadelphia 31, Pa. City Philadelphia, Pa.

	STANDARD CHARGE	A.H.S.P. ALLOWS
HOSPITAL CARE FROM 1/11/46 TO 1/22/46		
NO. OF DAYS (FULL BENEFIT PERIOD) 11 @ $5.00	60 00	55 00
NO. OF DAYS (25% BENEFIT PERIOD)		
OPERATING ROOM AND DELIVERY ROOM (FULL BENEFIT PERIOD)	10 00	10 00
(25% BENEFIT PERIOD)		
ANESTHESIA (FULL BENEFIT PERIOD)	10 00	10 00
(25% BENEFIT PERIOD)		
SURGICAL DRESSING (FULL BENEFIT PERIOD)		
(25% BENEFIT PERIOD)		
DRUGS (FULL BENEFIT PERIOD)	3 50	3 50
(25% BENEFIT PERIOD)		
LABORATORY (FULL BENEFIT PERIOD)	10 00	8 00
(25% BENEFIT PERIOD)		
X-RAY (FULL BENEFIT PERIOD)		
(25% BENEFIT PERIOD)		
ELECTROCARDIOGRAM (FULL BENEFIT PERIOD)		
(25% BENEFIT PERIOD)		
BASAL METABOLISM (FULL BENEFIT PERIOD)		
(25% BENEFIT PERIOD)		
PHYSICAL THERAPY (FULL BENEFIT PERIOD)		
(25% BENEFIT PERIOD)		
Nursery	5 00	4 50
Circumcision	5 00	
Nurses Board	4 50	
Telephone	30	
TOTAL	108 80	
★ ★ ★ ALLOWANCE BY ASSOCIATED HOSPITAL SERVICE	★ ★ ★ ★	91 00
BALANCE (PAID BY SUBSCRIBER TO HOSPITAL NAMED ABOVE)	17 80	

HOSPITAL SERVICES RENDERED TO ME FROM 1/11/46 TO 1/22/46 ARE HEREBY ACKNOWLEDGED AS FULL BENEFITS UNDER THE TERMS OF YOUR HOSPITAL SERVICE PLAN.

CHARGES OF $ 91.00 MADE BY THE HOSPITAL NAMED HEREON ARE ACKNOWLEDGED BY ME AS A PERSONAL OBLIGATION FOR SERVICES NOT INCLUDED UNDER THE TERMS OF THE PLAN.

(SIGNATURE OF SUBSCRIBER)

P-615

WE APPRECIATE YOUR COOPERATION IN BUILDING THIS NON-PROFIT COMMUNITY PLAN

James C Robinson: *Theory and Practice in Design of Physician Payment Incentives*:

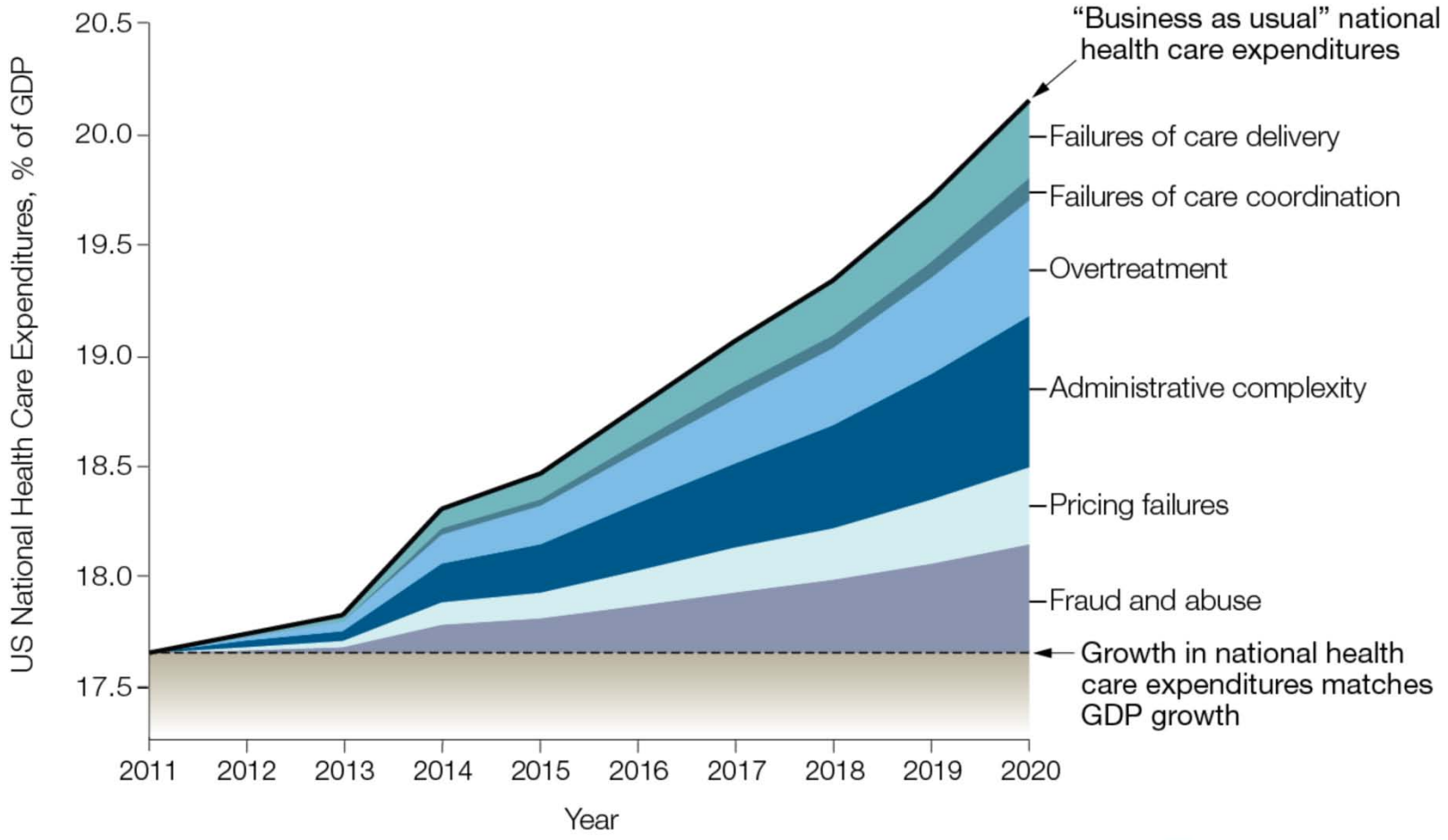
There are many mechanisms for paying physicians; some are good and some are bad. **The three worst are fee-for-service, capitation, and salary**. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of "ping-pong" referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem.

Robinson JC. Theory and Practice in design of physician payment incentives. Milbank Quarterly (79) 2001, p 1.

Another way to think about our healthcare challenges:

- We have **defective procurement**
- We are buying **the wrong things**
- We have not **adequately specified what it is we want to buy**
- But we sure are **getting a lot of it**
- **What happens if we think about activating physician professionalism?**

From: Eliminating Waste in US Health Care



Donald M. Berwick, MD, MPP; Andrew D. Hackbarth, MPhil

JAMA. 2012;307(14):1513-1516. doi:10.1001/jama.2012.362

Payment reform strategies and professionalism

- "Pay for performance"
  - Professionalism killer?
  - What were we paying for *before* we were paying for performance?
- ACOs
  - Start to move toward explicit rewards for outcomes patients want
  - But bookkeeping still FFS!
  - How to get doctors engaged?
- Advanced primary care
  - High value primary care services not in visits
  - Higher investment, maybe higher income

ABIM Foundation

Mission:

To improve health care through the advancement of medical professionalism.

FOUNDATION

abimfoundation.org

ABIMF Choosing Wisely Campaign

Choosing Wisely is an initiative of the ABIM Foundation to help physicians and patients engage in conversations about the overuse of tests and procedures and support physician efforts to help patients make smart and effective care choices.

Choosing Wisely®

An initiative of the ABIM Foundation

choosingwisely.org
#choosingwisely

ABIM FOUNDATION

Focus on physicians?

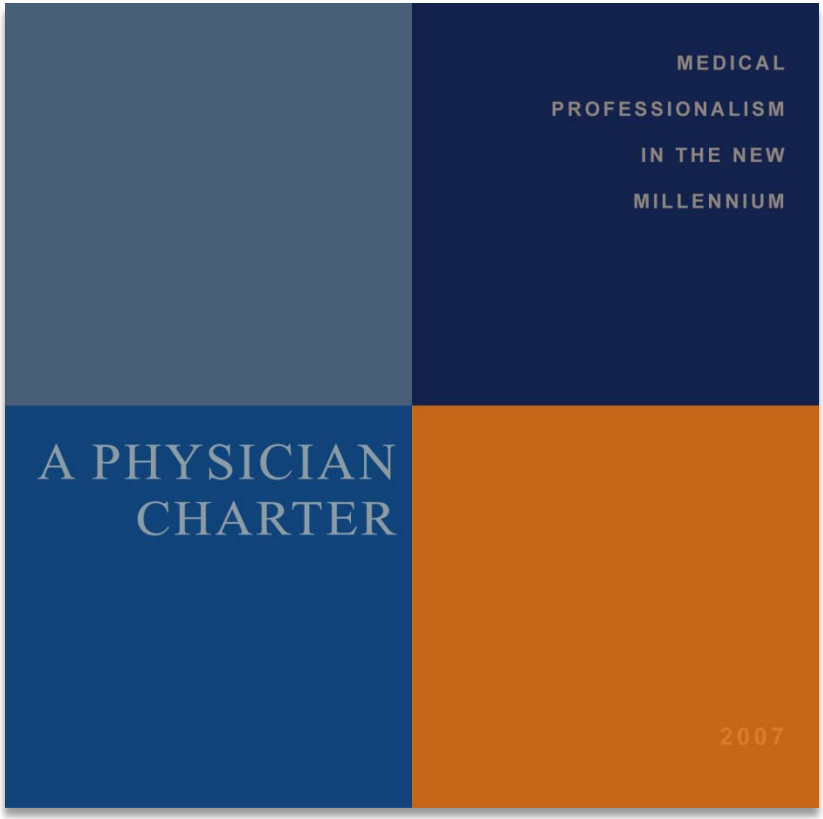
- Reduce waste
  - Initiatives such as Choosing Wisely that identify areas of potential waste (unnecessary tests and procedures) and encourage physicians to openly discuss options with patients
    - Physician decisions account for 80% of all health care expenditures
      - Crosson FJ. Change the microenvironment. Modern Healthcare and The Commonwealth Fund [Internet]. 27 Apr 2009
    - One-third of all physicians acquiesce to patient requests for tests and procedures—even when they know they are not necessary
      - Campbell EG, et al. Professionalism in medicine: results of a nation physicians. Ann Intern Med. 2007; 147(11):795-802

Choosing Wisely®
An initiative of the ABIM Foundation

What do Physicians Think of Overuse?

- **72%**: Say docs do it **at least once a week**
- **73%**: Say **somewhat or very serious** problem
- **66%**: Feel **responsibility** for avoiding overuse
- **58%**: Say docs in **best position** to address problem

Source: *Unnecessary Tests and Procedures In the Health Care System*. Conducted for The ABIM Foundation by PerryUndem Research/Communication. (2014).



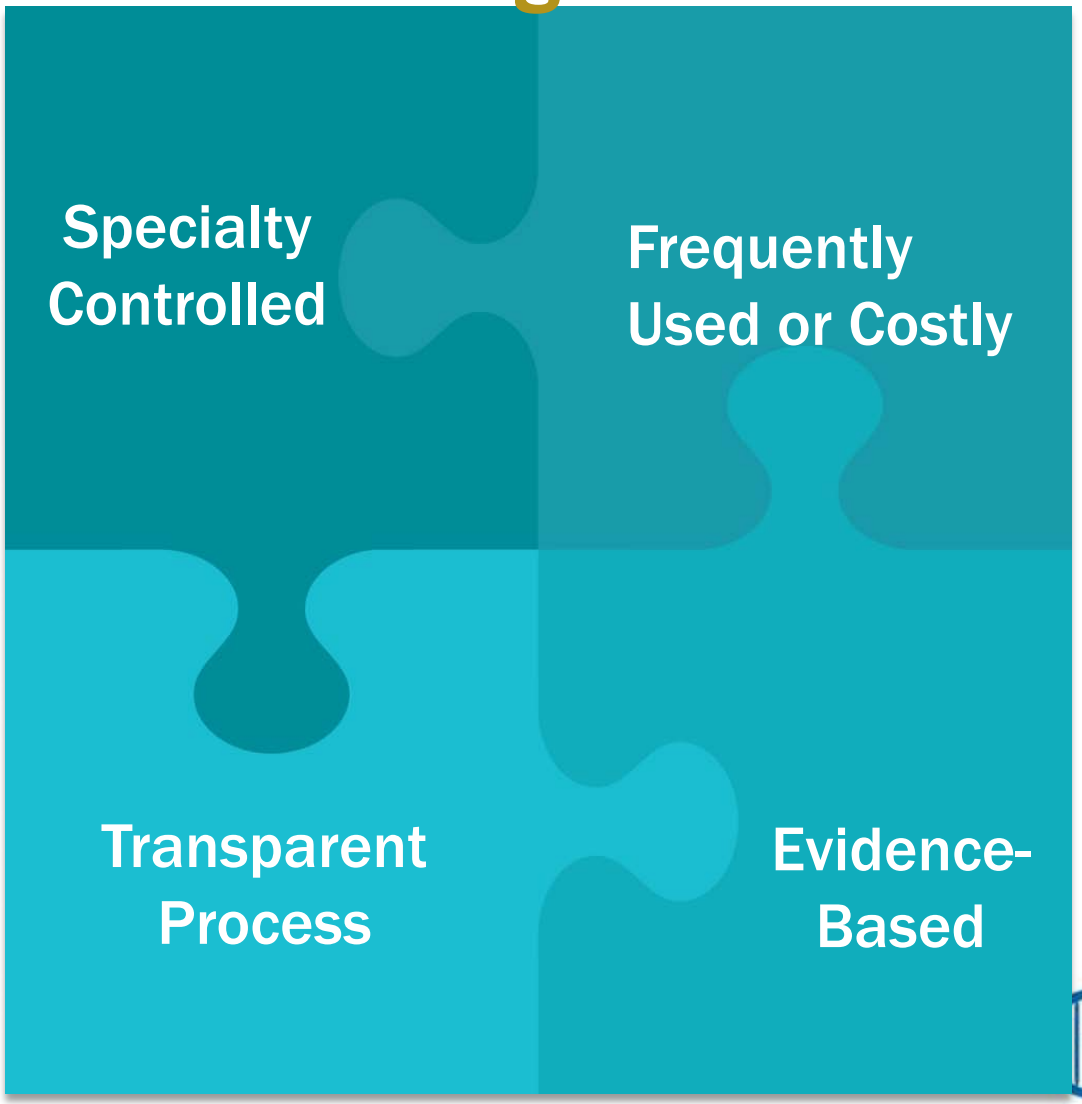
Fundamental Principles

- Primacy of patient welfare
- Patient autonomy
- Social justice

A Commitment to

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relations with patients
- Improving quality of care
- Improving access to care
- **A just distribution of finite resources**
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibilities

“5 Things” Lists



Society Partners

- American Academy of Allergy, Asthma & Immunology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Clinical Oncology
- American Society of Nephrology
- American Society of Nuclear Cardiology
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Otolaryngology—Head and Neck Surgery
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American College of Rheumatology
- American Geriatrics Society
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Urological Association
- Society for Vascular Medicine
- Society of Cardiovascular Computed Tomography
- Society of Hospital Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons
- AMDA – Dedicated to Long Term Care Medicine
- American Academy of Clinical Toxicology
- American Academy of Dermatology
- American Academy of Nursing
- American Academy of Orthopaedic Surgeons
- American Association for Pediatric Ophthalmology and Strabismus
- American Association for the Study of Liver Diseases
- American Association of Blood Banks
- American Association of Clinical Endocrinologists
- American Association of Neurological Surgeons
- American College of Chest Physicians
- American College of Emergency Physicians
- American College of Medical Genetics and Genomics
- American College of Medical Toxicology
- American College of Occupational and Environmental Medicine
- American College of Preventive Medicine
- American College of Surgeons
- American Dental Association
- American Headache Society
- American Medical Society for Sports Medicine
- American Physical Therapy Association
- American Psychiatric Association
- American Society for Radiation Oncology
- American Society for Reproductive Medicine
- American Society of Anesthesiologists
- American Society of Colon & Rectal Surgeons
- American Society of Hematology
- American Thoracic Society
- Commission on Cancer
- Heart Rhythm Society
- North American Spine Society
- Society for Cardiovascular Angiography and Interventions
- Society for Cardiovascular Magnetic Resonance
- Society for Maternal-Fetal Medicine
- Society of Critical Care Medicine
- Society of General Internal Medicine
- Society of Gynecologic Oncology
- The American Academy of Physical Medicine and Rehabilitation
- The Endocrine Society

Strategic Partners

ConsumerReports® Health → 32 Consumer Partners

Robert Wood Johnson Foundation → 21 State & Regional Grantees

Consumer Partners

Founding Partners

- AARP
- Alliance Health Networks
- Midwest Business Group on Health
- National Business Coalition on Health
- National Business Group on Health
- National Center for Farmworker Health
- National Partnership for Women & Families
- Pacific Business Group on Health
- SEIU
- The Leapfrog Group
- Wikipedia

National Partners and Specialty Societies

- National Hospice and Palliative Care Organization
- Society for Participatory Medicine
- Union Plus

Regional Partners

- The Alliance
- Baby Boomers for Balanced Health Care
- California Grower Foundation
- Connecticut Choosing Wisely Collaborative
- Covered California
- Detroit Regional Chamber
- Greater Detroit Area Health Council
- Healthcare Collaborative of Greater Columbus
- Minnesota Health Action Group
- Oregon Health Care Quality Corporation
- Pittsburgh Regional Health Initiative
- Rhode Island Business Group on Health
- VNA Community Healthcare
- Washington Health Alliance
- Washington State Hospital Association
- Washington State Medical Association
- West Virginians for Affordable Health Care

What Is On The Lists?

1

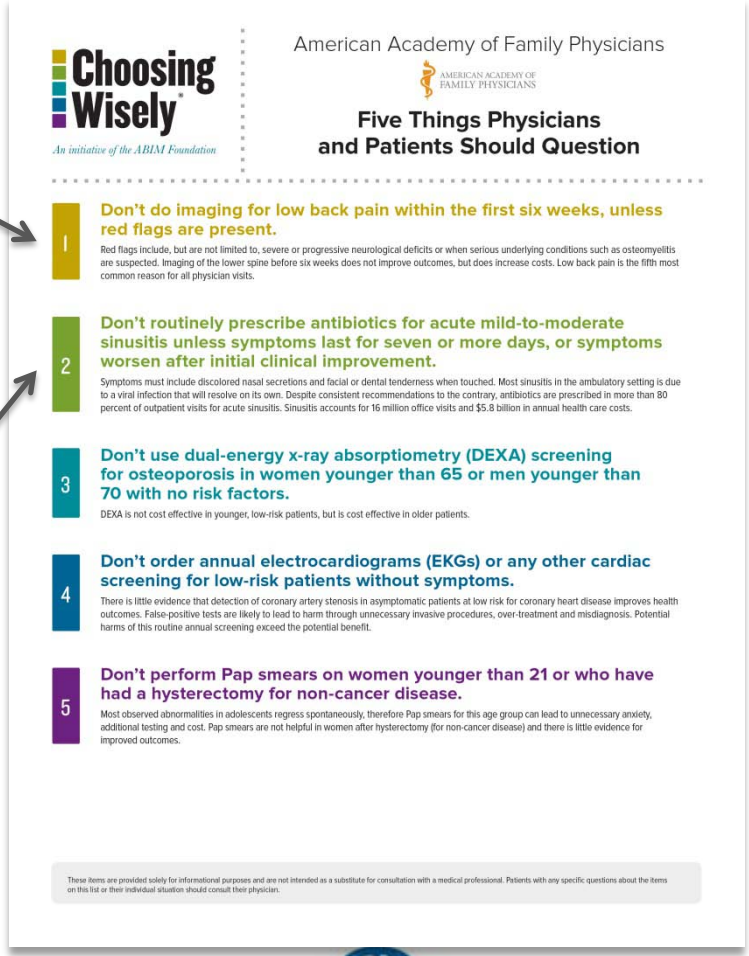
Don't do imaging for low back pain within the first six weeks, unless red flags are present.

Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs. Low back pain is the fifth most common reason for all physician visits.

2

Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.

Symptoms must include discolored nasal secretions and facial or dental tenderness when touched. Most sinusitis in the ambulatory setting is due to a viral infection that will resolve on its own. Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80 percent of outpatient visits for acute sinusitis. Sinusitis accounts for 16 million office visits and $5.8 billion in annual health care costs.



Choosing Wisely
An initiative of the ABIM Foundation

American Academy of Family Physicians
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Five Things Physicians and Patients Should Question

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3 **Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.**

DEXA is not cost effective in younger, low-risk patients, but is cost effective in older patients.

4 **Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.**

There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Potential harms of this routine annual screening exceed the potential benefit.

5 **Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.**

Most observed abnormalities in adolescents regress spontaneously, therefore Pap smears for this age group can lead to unnecessary anxiety, additional testing and cost. Pap smears are not helpful in women after hysterectomy (for non-cancer disease) and there is little evidence for improved outcomes.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

Call to the Profession: Where Are the Health Care Cost Savings?

Deficit pressures are making cost control inevitable. It will only be successful if physicians stop looking to others to find solutions and focus on approaches that improve the care for patients with chronic illnesses.

-Ezekiel J. Emanuel, MD, PhD

VIEWPOINT

Where Are the Health Care Cost Savings?

Scan for Author Audio Interview

Ezekiel J. Emanuel, MD, PhD

AS OF JULY 2010, THE UNITED STATES SPENT $2.6 TRILLION per year on health care.[1] It is not just the level of spending that is of concern but the rate of growth over time. During the last 30 years, the growth in US health care spending has been 2.1% more per year than growth in gross domestic product (GDP). This is why the percentage of GDP attributable to health has nearly doubled in 30 years. At this rate, projections suggest that by 2040 1 of every 3 dollars will be spent on health care and by 2080, it will be nearly 1 of every 2 dollars.[2] In 2010, the entire GDP of France was $2.58 trillion, the world's fifth-largest economy. That means US health care spending is equivalent to the world's fifth-largest economy.

False Cost Control

Physicians often gravitate to cost control proposals that do not involve their own role and changing their practices, whereas policymakers may propose solutions that will not significantly reduce costs. In assessing cost control proposals, 2 criteria are fundamental. One criterion is that 2% growth in health care costs over growth in GDP amounts to $52 billion a year; serious proposals are aimed at reducing the growth in health care costs to 1% over GDP growth. Consequently, anything short of $26 billion in savings is not credible. A second criterion is that cost control proposals should transform the delivery of care and lead to improved quality as well as patient and physician satisfaction.

Malpractice Costs. Physicians frequently cite malpractice premiums and the cost of defensive medicine as drivers of high costs. A recent Congressional Budget Office (CBO) analysis estimated that a package of reforms consisting of a $250 000 cap on noneconomic damages, a $500 000 cap on punitive damages, reducing the statute of limitations (1 year for adults and 3 years for children), and implementing fair-share liability could reduce malpractice premiums by 10% ($3.5 billion per year) and reduce defensive medicine for the entire health care system by 0.3% ($7 billion), for a total savings of approximately $11 billion or 0.5% of national health care spending per year.[3] No reliable data indicate that other malpractice reforms would generate cost savings.

Importantly, more than 30 states have instituted similar caps and limits. If these measures have reduced costs, they are insufficient to counter other factors increasing costs. In addition, physicians in those states, such as California, do not seem to indicate that the practice environment is better. There is little research on the effects of malpractice caps on quality, although 1 study cited by the CBO suggested that caps lowered the quality of care.[4] This suggests that limits on malpractice liability would not likely both reduce costs and improve quality.

Insurance Company Profits. Another proposed cost control mechanism focuses on the profits of insurance companies. In 2010, the combined profits of the 5 largest insurers—Wellpoint, United, Aetna, Humana, and Cigna—increased substantially, reaching $11.7 billion.[5] It may be worthy to reduce these profits, but in the scheme of $2.6 trillion in national health care spending, this amount constitutes just 0.5% of total spending.

Drug Costs. In 2010, the United States spent $262 billion on prescription drugs, 10% of total health care spending.[1] There is a worrisome trend that new drugs and biologics costing tens of thousands of dollars per year do not provide cures, but achieve only modest disease benefit. One approach to cost savings is drug reimportation, which would allow brand-name drugs sold at lower prices in Canada or other countries to be imported into the United States. Assuming the logistical and supply problems were solved, the CBO estimated that reimportation could save approximately 1% of drug costs, an insignificant $2.6 billion.[6]

Another approach might be to substitute generic drugs for brand-name drugs. Between 2004 and 2009, use of generic drugs increased substantially from 57% to 75% of all prescriptions.[7] Despite this change, costs for health care and for prescription drugs have both increased by approximately 25% during those years. By increasing generic prescription levels to 100%—an unrealistic level—CBO estimated that an additional $900 million could be saved for Medicare Part D in 2009.[8] Of the $502 billion spent on Medicare in 2009, this would amount to a savings of less than 0.2%. The US Department of Health and Human Services recently concluded that increased savings from expanding generic use "are likely to be small relative to total spending on drugs"[7]—not to mention total health care costs.

"The Million Dollar Baby." Many physicians believe the US health care system expends excessive amounts on so-called "million dollar babies"—patients who spend long periods in intensive care units and require tracheostomies, gastrostomy tubes, and myriad other interventions. However, an analysis of nearly 20 million commercially insured patients revealed that only 255 patients had consumed more than $1 million each on health care expenditures in 2010. Extrapolating to the entire health care system suggests these patients use 0.5% of all health care costs. Even if all costs attributed to care of these "million dollar babies" could be eliminated, there are not enough of such patients to significantly reduce health care spending. Expanding this group to patients who consume more than $250 000

Author Audio Interview available at www.jama.com.

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Choosing Wisely®

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American Board of Internal Medicine (ABIM)

Mission:

To enhance the quality of health care by certifying internists and subspecialists who demonstrate the knowledge, skills, and attitudes essential for excellent patient care.

Role:

- Defines specialties and subspecialties in internal medicine
- Offers a professionally embraced definition of “the good doctor”

American Board of Medical Specialties®

Higher standards. Better care.™

24 Member Boards

Certify more than 750,000 physicians

- Allergy & Immunology
- Anesthesiology
- Colon/Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine (200,000+)
- Medical Genetics
- Neurological Surgery
- Nuclear Medicine
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine & Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Psychiatry & Neurology
- Radiology
- Surgery
- Thoracic Surgery
- Urology

American Board of Internal Medicine

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The Breadth of Internal Medicine

- Adolescent Medicine
- Adult Congenital Heart Disease
- Advanced Heart Failure & Transplant Cardiology
- Cardiovascular Disease
- Clinical Cardiac Electrophysiology
- Critical Care Medicine
- Endocrinology, Diabetes, & Metabolism
- Focused Practice in Hospital Medicine
- Gastroenterology
- Geriatric Medicine
- Hematology
- Hospice and Palliative Medicine
- Infectious Disease
- Interventional Cardiology
- Medical Oncology
- Nephrology
- Pulmonary Disease
- Rheumatology
- Sleep Medicine
- Sports Medicine
- Transplant Hepatology

- ✓ Certify 1 of every 4 practicing physicians in US
- ✓ More than 200,000 ABIM Board Certified Physicians
- ✓ Internal Medicine has more Board Certified Physicians than any other Board

Maintenance of Certification

- Designed to ensure that physicians keep current
- Expresses core values that the good doctor
  - Keeps up with changes in knowledge and practice
  - Incorporates the values and preferences of patients in care
  - Measures and improves performance
  - Practices safely

Payment models depend on important physician skills and behaviors

- Teamwork
- Care coordination
- Preventive Care
- Resource awareness
- Attention to “non-medical” issues
- Clinical system re-design
- Ongoing improvement
- Use of health information technology

We will need to change training

AND

We will need to change practice

Role for ABIM

- What does the good doctor know and do in the 21st century?
- How do we prepare trainees to function in these new models?
- How do we support those in practice by articulating new skills they will need?
- How do we assess it all in a publicly credible way?

Questions?