James L. Holly, M.D.

Entrepreneurism versus Professionalism Part II
Republicans and Democrats Both Have it Wrong
By James L. Holly, MD
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Last week's article entitled, "Entrepreneurism vs. Professionalism," engendered the following response from one reader.

> "I agree with the article but the problem is that most physicians won't do what you have suggested…and most patients either lack the knowledge or don't care what tests a physician orders as long as they don't have to pay for them…There has to be a systemic solution to the problem…The next step will be the rationing of care or the practicing of rational care…I wish it wasn't going to be that way…Do you think there is an alternative…?"

The questions framed by this reader, who is a healthcare colleague, and who has been both a participant in and an observer of healthcare issues for over 20 years, are "right on point." The short answer is; there is an alternative.

Republicans and Democrats Both Have it Wrong

Let's summarize what this writer thinks about the current healthcare debate. First, both Republicans and Democrats have it wrong. Republicans blame lawyers and particularly trial lawyers for the escalating cost of healthcare. That is a political judgment, not a rational one. Doctors, who have felt victimized by frivolous lawsuits and who have paid escalating malpractice premiums, were delighted to accept this explanation of healthcare cost because it distracted everyone's attention from the subtle but dramatic changes which were taking place in how healthcare was being delivered and with how provider and patients responded to one another. Defensive medicine became a popular explanation for healthcare costs; but, was it?

Democrats, wanting to change healthcare, needed a straw man in order to motivate people to support radical change in healthcare. Not wanting to fail as others had, the President chose to demonize the insurance companies. The problem is that while he chose an unpopular and easy target, he chose a target that has little to do directly with the rising cost of healthcare. Republicans, not analytical or thoughtful enough, failed to point this out to the President and to the American people.

To blame insurance companies for increasing healthcare cost is like blaming the police for increasing crime rates. Police can indirectly allow an increase in crime but they do not cause crime or crime rate increases. Insurance companies' premium rates reflect the rising cost and utilization of healthcare; they did not directly produce the increased cost.

Indirectly, by the nature of their industry, they unwittingly contributed to the cost of care by insulating policy holders from the shock of the true cost of their care. They tried to address this with deductibles, co-pays and prior authorizations, but these steps only made them look greedier and greedier. Managed care was supposed to address the trajectory of healthcare costs but also actually only aggravated the problem. Why? Read on. What was not obvious to the President, the Democrats or the Republicans, is that controlling insurance premium rates will do NOTHING to control the cost of healthcare. In fact, a number of the elements of the healthcare reform bill will only further aggravate the escalating cost of healthcare; ultimately requiring the government to "take over" insurance companies which cannot print money, or spend more than they make as the government can.

Insurance companies did not create entrepreneurship in medicine; Medicare did. Insurance companies did not create expensive technology in medicine; progress did. Insurance company rates do not create the expensive of healthcare; those rates only response to the cost. This author believes that there have been and that there are excesses in the health insurance industry, but the limiting of the growth of insurance premium rates will do absolutely nothing to reduce or control the cost of healthcare. Neither tort reform nor insurance regulations will solve the problem of healthcare cost.

So Commonly Accepted, No One Questions It

Healthcare reform has been based on assumptions: something so commonly believed that no one questions it. The premise that there is a great deal of expense added to healthcare by "defensive medicine" is one such belief. No doubt that some tests or procedures are done out of fear of "missing something," and of being called to task for it. But that happens less often than one might imagine. In 37 years of practicing medicine, I do not remember a single instance where I ordered a test with the conscious thought, "This will protect me from a law suit." However, I was often confronted with the thought, "If I order this test, I will make money, but does the patient need it and will it help in the patient's care?"

With the above being said, there is one place where "defensive medicine" has increased the cost of care. An analysis of that "place" will actually point us to real solutions to cost containment in healthcare. That place is the emergency room. Almost everyone, who shows up in the emergency room with a headache, gets a CT scan of the head. That is not rational but it helps insure that the emergency room physician will not be accused of neglect if a patient dies or has a serious health problem when they leave the ER. Because more and more people used the emergency department for their primary care, the ER became a laboratory for examining the drivers of healthcare cost, and the ER became a significant driver of cost increases.

Why is this so? Are all emergency room physicians incompetent, or is there a conspiracy to help increase revenue for the hospital? Absolutely, not. The quality of emergent care has improved

immeasurably since the advent of full-time, on-site emergency physicians in the ER. There are three reasons for the cost of care increase in the ER; and, these reasons apply in many other areas of healthcare delivery.

The first is that the transition from care in the emergency room and care in the inpatient or in the outpatient settings often lacks continuity. The examination and the evaluation of the patient in the emergency room and the follow-up of that patient by the primary care physicians are often disjointed and sometimes even uncertain or untimely. This makes the emergency room physician feel the necessity of ordering tests which might be avoided if he/she could be confident that the patient would be followed-up soon and that the ER physician's evaluation and impression would be available to the primary care physician. This is the reason for the Physician Consortium for Performance Improvement's (PCPI) publication of an 18-point-set of quality measures which dictates what needs to transpire in order to eliminate the loss of continuity in the patient's care. (see Your Life Your Heath, March 10, 2010 at www.jameslhollymd.com for a more thorough discussion of this point and for a discussion of how SETMA has applied the PCPI Care Transitions quality measures..)

The second reason for the emergency department contributing to the cost of healthcare, is that this disjointed care does not only occur in the transition from ER to outpatient care; it also occurs from ER visit to ER visit. Not only do patients get a CT scan of the brain when they show up in the ER with a severe headache the first time but they often get a CT scan every time they show up in the ER. And, because there is little communication between the ER in one hospital and the ER in another, the loss of continuity of care is aggravated. If all providers and all emergency departments had access to a common data base the continuity of care could be maintained and the cost of that care could be decreased without the quality of that care being compromised.

The third and most important reason for ER medicine's contribution to the cost of healthcare is that there is no emotional bond between the ER physician and the patient. Increasingly, there are fewer emotional bonds – read that personal and trust relationships – between most providers and their "clients." As the science of medicine grew, providers and patients came to depend more upon technology than upon personal relationships. As trust, due to impersonal relationships eroded, a greater and greater dependency upon technology developed. As society placed less and less value upon trust, more and more value was placed upon, impersonal and expensive technology. As less and less personal responsibility was taken for one's own life and choices, more and more dependency was placed on technology to "take care of" the consequences of those wrong choices.

Rational Medicine Only Possible when Trust Exists

As my colleague's comment at the first of this article states, "only rational medicine will control the cost." But, rational medicine can only be practiced in a context where there is consistent continuity of care from one provider to another and from one institution to another, and rational

medicine can only be practice when an emotional bond – a trust bond – exists between the provider and the patient. It is that trust relationship which allows the benefit of technology to be utilized for the patient without the excesses of technology abuse being substituted for the lack of a personal bond. While that emotional bond is not impossible in a technological age, everything about our society is moving us away from personal interaction and interdependency, to impersonal, remote relationships.

As the cost of care escalated into a crisis, managed care was introduced which while it was supposed to and which while it actually can impact the overall cost of medical care, it unwittingly increased the cost of that care. It did so by accelerating the dissolution of already strained emotional ties between providers and patients. Managed care placed the emphasis on the patient's relationship with the insurance company rather than on the healthcare provider. Thusly, managed care aggravated the problems created by the lack of intimacy and trust in the patient/provider relationship, again making technology more necessary in order to satisfy patients that they were receiving excellent care. In these circumstances, patient demands and provider needs increased the cost of healthcare tremendously. More because better and expensive and excellence became synonymous in the minds of patients.

Medicare Became a Piggy Bank

But if the loss of continuity of care and if the loss of personal relationships were not enough, there was a third principle driver to the accelerating cost of healthcare which is the "payment method.". The principle payment mechanism in healthcare has been "piece work," i.e., as ladies who once ironed clothes for a living were paid a nickel for a shirt, a dime for a pair of pants and a penny for a handkerchief, so physicians were paid by the "piece." All that a healthcare provider had to do to increase his/her income was to "do more pieces." When healthcare was less technologically driven the flaw in this design was not obvious, but when the pieces began to sell for hundreds and even thousands of dollars each, problems developed. Without quality and/or outcomes controls, the number of pieces escalated without any improvement in the quality of care.

No one measured whether the tests, studies, procedures, surgeries or other "piece work" improved the patients' care; the only measure was how many of them were done. Even if 90% of the studies done were normal, there was no limited placed on more being done. Even if there was no evidence that the "piece" contributed to the health or welfare of the patient; it was paid for. Healthcare for the provider and the patient came to be defined by tests, procedures, studies and other forms of "piece work."

Patient-Centered Medical Home (PC-MH) or Health Home

If then the lack of continuity of care and the lack of trusting relationships between healthcare providers and their patients, and if the method of reimbursement are the principle drivers for the increased cost of healthcare, what is the solution?

This column has published numerous articles about PC-MH. They can all be found at www.jameslhollymd.com. At its foundation, an emotional bond – a trust bond –between the healthcare provider and the patient is the genius of the patient-centered medical home movement, which is why it is the only long-term, permanent solution to the rising cost of healthcare. All physicians will tell you that there are patients who do not demand the high-cost, low-yield technology of medicine but who will listen to the physician about "watchful waiting" because **they trust the provider's caring for them and knowledge of medicine.** .

Terms which are part of the PC-MH vocabulary are "integration of care," "coordination of care", "continuity of care" and "excellence of care." In reality, these are only aspects of a personal-trust relationship existing between the patient and the provider, with that that trust relationship being structured around quality metrics, evidence-based medicine and a consistent application of both in the care of each patient. The use of electronic patient records adds the ability to examine measure and report care consistent with national standards. Both the personal interaction and the public reporting of quality outcomes begins to replace the dependency upon and trust of technology with the personal trust which marked healthcare fifty years ago. With that trust and with the confidence that every thing which should be done has been and/or is being done, the rate of increase in the cost of healthcare can begin to decrease.

The genius of PC-MH is to discover the true implications of SETMA's motto which was adopted in August, 1995, which is, "Healthcare Where Your Health is the Only Care." It is to put the patient and their needs first. And, it is to include the patient as a member of the healthcare team. There are 8,760 hours in a year. If responsibility for a patient's healthcare is seen as a "baton," the patient carries that "baton" for over 8,700 hours a year. PC-MH promotes methods for effectively "passing the baton" to the patient so that the patient's healthcare does not suffer under the patient's own care. SETMA has also placed the patient's healthcare at the center of our healthcare delivery in many ways. One way is that we developed The SETMA Foundation through which we help provide funding for the care of our patients who cannot afford it. Our resources are meager in comparison with the need, but it is a start.

The following is one example of many of how PC-MH and the SETMA Foundation have worked together to restore professionalism to healthcare. This patient who came to the clinic angry, hostile and bitter was found not to be a bad person but depressed because he could not work, could not afford his medication and was losing his eye sight. He left the clinic with The Foundation paying for his medications, giving him a gas card to get to our ADA certified DSME program, waiving the fees for the classes, helping him apply for disability, and getting him an appointment to an experimental program for preserving his eyesight. He returned in six weeks with something we could not prescribe. He had hope and joy. By the way, his diabetes was to treated to goal for the first time in years. This is PC-MH; it is caring and it is humanitarianism. .

Medicare Advantage

As the Patient-Centered Medical Home is restoring the personal aspect of healthcare, the Medicare Advantage (MA) program and/or the Accountability of Care Organizations (ACO) are modifying the "piece" payment system of healthcare. While the President has been convinced by those who do not understand that Medicare Advantage is the problem; it is the solution. The supposed increase in the cost of Medicare Advantage is because it is being compared to traditional Medicare costs where the administrative cost of Medicare is not calculated in the formulae. There are bright examples of success with Medicare Advantage, success marked by quality outcomes and high patient satisfaction. That success also is marked by a dramatic change in the trajectory of health care cost while maintaining its quality.

Evidenced-based Medicine and Quality Metrics: Process and Outcomes

The third piece to true healthcare transformation is changing the way physicians are paid. The foundation of that change must be evidenced-based medicine. This is medicine which is based on appropriately designed studies which can measure the value of interventions or treatment strategies. Patients may receive any medical treatment which is not specifically prohibited by law, but the government and insurance should only pay for that treatment which is based on scientific evidence as to its efficacy.

In addition, there should be a limit on how many procedures can be done which are normal. Historically, Medicare will only pay for one lipid analysis per year unless the patient is on treatment. This same provision could apply to other forms of treatment or evaluation. If a test, particularly an expensive test, is done by a healthcare provider repeatedly and the results are repeatedly normal, then that provider should either be monitored. or removed form the panel of providers eligible for Medicare payments.

This principle has long been recognized in healthcare. For instance, if a surgeon does 100 appendectomies, and 60% of them are normal; he/she is doing too many appendectomies. If he/she does 100 and 98% of them are abnormal, the surgeon is not doing enough. No one can get it right every time but if they get it wrong too often, then their judgment is poor, or their criteria for doing a procedure , study or tests is wrong. Evidenced-based medicine can be used to determine what the proper standard is for all procedures and tests.

Also, the cost curve can be changed for healthcare by including quality process and quality outcomes in the payment formula. There are fledgling programs such as the Physician Quality Reporting Initiative (PQRI) where healthcare providers are being paid for the demonstration of quality outcomes rather than just for piece work. The accountability of the pubic reporting of provider performance on quality measures completes this picture. This is why SETMA has begun quarterly reporting on our website of our providers' performance on multiple quality

metrics. Included in that reporting is the examination of whether disparities of care in ethnic and socio-economic groups have been eliminated..

Conclusions

These are not simple matters. The solutions are not easy but the do exist. Unfortunately, there is nothing in the healthcare reform bill which does anything to address these issues. The healthcare reform debate must be refocused if we are to solve the problems we face without sacrificing the quality of care and without sacrificing the human aspects of healthcare. Healthcare is a profession. The above described methods of dealing with healthcare preserve it as a profession while dealing constructively with the business of medicine. Physicians would do well not to allow entrepreneurism to compromise the professionalism of medicine.