North Coast Physician

In This Issue:

Cover Photo
"Mastodon Skull #1 - 2011"
Stephen Kamelgarn, M.D.

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

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NEWS OF THE DAY

LEE LEER, M.D.

Recently I saw a patient who scheduled an appointment to have a couple of skin lesions checked. When I entered the room, however, his agenda had expanded: he had experienced an episode of intense chest pain a week earlier, along with some palpitations. He thought it was his GERD, but wondered if it might be his heart. So, in the course of about 20 minutes, we did (1) an EKG, (2) a shave biopsy of a skin lesion, (3) a focused cardiac history and physical, (4) reviewed his GERD treatment, and (4) discussed our families. He left satisfied, with all his questions answered. Needless to say, after fleshing out the details of his history of chest pain and reviewing the EKG, it was clear that that his coronary arteries were not contributing to his symptoms.

How do I get compensated for this visit? Not significantly better than had I referred him to a cardiologist and a dermatologist. He would, however, have had at least two additional co-pays and incurred significantly more cost to the "system."

Contrast this with an acquaintance of mine whose PCP does not apparently do skin biopsies, and who had to wait quite some time for a referral to a dermatologist so he could have a 9 minute visit to get a small shave biopsy.

How, I wonder, does the "system" measure quality in these two situations? And, I wonder if the policy makers who say that advanced practice providers (nurse practitioners and physician assistants) can and shall take over the roles of primary care physicians in the future truly understand that very few people other than a well trained family physician – with a long relationship with his patients – could have provided the same high quality, cost-effective care that I did in 20 minutes.

I make a good living, and am absolutely not complaining about compensation. However, I guarantee you I was not paid appropriately for the visit I've described. Nor would all that I did give my practice any more brownie points towards being a complete "medical home" than my acquaintance's doctor would have gotten for coordinating a referral or two.

Friends of mine, in other parts of the state, work in systems that recognize and indeed are built around the sort of quality primary care that I describe above. Such a system, sadly, does not exist here. Here, instead, we have hard working specialists who are burdened with unnecessary referrals, and we have no structural coordination between specialty and primary care practices. Further, we have little if any communication between Eureka's best hospital and surrounding outpatient practices. In spite of efforts by well-intended physicians, we have no formal ongoing dialogue between hospitalists and outpatient doctors. Further, we actually have one specialty practice whose physicians refuse to speak with PCP's on the phone. Mind you, this is by far the exception, and most of my non-primary care specialty colleagues are exceedingly responsive and helpful, but still! What has the community come to?

As if this all wasn't enough to drive us to retire early and often, we now also have to contend with what is, as far as I can discern, a random guessing game when it comes to ordering imaging studies. I truly do not believe it is possible on the first try to order the study that radiology thinks I really want or need for my patient. Yes, I understand that most of this joyful experience is motivated by payers and their requirements, but there must be a better way than for all of us to drive each other crazy!

Imagine instead the following: PCP's and specialists meet regularly to develop and refine care protocols, and to discuss difficult patients. Phone consultations are frequent and encouraged. Said consultations occasionally lead to recommendations for imaging studies. Radiology, knowing the diagnosis, rule out's, and clinical questions, recommends and arranges whatever the most appropriate and cost effective study is… and orders any necessary pre-study lab work without bothering the ordering physician (other than for a final sign off on the order). Imagine if the hospital IT department worked closely with each community practice to make sure that easy and instant electronic communication was accessible and functioning. Imagine further that PCP's kept accurate and complete EMR's so that the hospitalists (who always review outpatient records) could get a better picture of their patients and provide more efficient and cost-effective care. Then imagine that discharge summaries were always available on the day of discharge. Imagine a care transition process that involved the PCP BEFORE the patient left the hospital. Imagine further that outpatient and inpatient providers worked collaboratively to design systems that function best for all involved.

Finally, imagine a system that, instead of financially rewarding physicians and institutions for the use of the latest "Higgs Boson Accelerator" for the treatment of [insert disease here], instead rewarded us in such a way that we'd be encouraged to provide, and continuously improve on, care

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that matters.

In a stumbling, awkward way that can only happen in America's non-healthcare system, this is sort of what the Affordable Care Act is trying to accomplish with Accountable Care Organizations, or ACO's. Ultimately, I think we'll get to these primary care based, quality driven organizations. But along the way, we'll have to work our way around some substantial problems. Not the least of which is how to really define a medical home and how to recognize and reward truly thorough primary care. Another is that some of the institutions with enough resources to actually move towards a functioning primary care based ACO are instead interested in consolidating power and control (and, let's be honest, money). Another is that physicians – especially those of us in solo and small group practices – are not good team players. We don't think in terms of systems, we all think we know best (in spite of evidence to the contrary that any of our significant others would be happy to provide). I believe some of us just want to hang on until we retire, and will resist change with every fiber of our being.

Not that these problems are insurmountable – as I say, I do predict we'll get there. And most of us in healthcare will be able to cope with and ultimately thrive on the inevitable changes we face. However, some of us: physicians, nurses, and administrators, will simply not be able or willing to grasp the complexities or even the simplicities of change. This minority must be left behind, left to their own devices, but must not be allowed to sabotage true progress. Any entity or system that strives to satisfy the lowest common denominator is doomed to fail. Likewise, any system adhering to an inflexible dogma does not have the best interests of the population in mind, and will ultimately fail. However, a system that chooses to only employ the best and the brightest, that can move beyond sectarian blinders to truly place the patient and the community first does indeed have a chance to survive. Will it happen here, during our careers? The fun and exciting news is: it's up to us! The discouraging and intimidating news is: it's up to us!

"PACE", Continued from Pg 6

structure provides the incentive to deliver the right care at the right time, and in the right place.

There will be a combined Medical Director/Primary Care Physician position affiliated with Redwood Coast PACE. This position will be responsible for medical oversight of the program and will lead the Interdisciplinary Team in managing the care of the program participants. Other members of the IDT include a nurse practitioner, program director, center manager, nurse, physical and occupational therapists, nutritionist, social worker, and additional clinical and support staff.

This is an exciting time as we look to the future of care for older adults in Humboldt County. Once all approvals and licensure are secured, Redwood Coast PACE would be the first rural PACE program in California. Once open, it would give our patients and their families a new option for comprehensive, all-inclusive care that will improve the quality of their lives and provide an alternative for placement in skilled nursing facilities.

References

1. Meret-Hanke LA: Effects of the Program of All-inclusive Care for the Elderly on hospital use. Gerontologist 2011 Dec, 51(6):774-85
2. Hirth V, Baskins J, Dever-Bumba M: Program of All-Inclusive Care (PACE): Past, present, and future. JAMDA 2009 March, pp 155-160

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