

From the Editor

Mad as Hell and Not Going to Take It....

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Dr. Stefanacci continues to build on his work as the 2003-2004 Health Policy Scholar at the Centers for Medicare & Medicaid Services (CMS), where he helped develop and implement the Medicare Part D Pharmacy Benefit. He is currently creating a LTC Management Degree Program for undergraduate and graduate students in the Geriatric Health Program, Center for Medicare Medication Management (cm³), Mayes College, University of the Sciences in Philadelphia (USP).

As a geriatrician, Dr. Stefanacci has worked in LTC for decades as medical director for several nursing facilities and continuing care retirement communities. He has also served as a medical director for primary care private practices, full-risk provider groups, Medicare + Choice HMO (M+C) programs, and the PACE (Program for All-inclusive Care for the Elderly) program in Philadelphia. Dr. Stefanacci provides direct patient care for the St. Agnes LIFE program and works with Newcourtland on innovative LTC services such as electronic dispensing and prescribing systems for the company's facilities. He also serves as executive director of HepTREC, the Delaware Valley Hepatitis Treatment, Research and Education Center.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and earned a fellowship in Geriatrics at the same institution.

Dr. Stefanacci participates actively in the American Medical Directors Association (AMDA), Academy of Managed Care Pharmacy, American Society of Consultant Pharmacists (ASCP), and the American Geriatrics Society (AGS). He is a fellow in both the College of Physicians of Philadelphia and AGS and an honorary lifetime member of ASCP. He is editor-in-chief of *Assisted Living Consult* and *Medicare Patient Management* and serves on the editorial boards of *Consultant Pharmacist*, *American Psychiatry News*, *LTC Interface*, *Managed Care*, and *Jefferson's Health Policy Newsletter*.

Dr. Stefanacci's proudest accomplishment is as founder and member of the board of directors of www.Go4TheGoal.org.

Pardon my rant, but I'm going to take the opportunity in this editorial to launch into a tirade about all that is wrong in the world or at least in the world of Medicare. I'm sure that any Medicare provider can make a list similar to this one during the course of a day. In addition to exposing the problems that we all are facing, I hope to provide some solutions. And perhaps even more than that, I hope to evoke responses of solutions and motivation to improve our situation and, more importantly, the situation of our patients.

Administrative Burdens

So, where to begin? Let's start with perhaps one of the most bothersome issues—the daily administrative burdens. Just the other day I received a letter from a Medicare Part D prescription plan denying my patient access to a prescription that I had written. What was most annoying about this letter was that the only information provided was that my order had been denied. I called the 800 number and waited on hold for 10 minutes to find out what medication the payor wanted me to use, since this simple information was not included in the letter. I was told they just needed my reason for ordering this medication. Once I explained the reasoning for my selection (actually it was a continuation of a medication that she had been on for some time), Medicare approved the selection. This is an unnecessary burden with no upside for those physicians who make thoughtful, clinically appropriate decisions.

Yet another daily occurrence of the endless administrative burdens is Medicare's pay-for-performance system. The Physician Quality Reporting Initiative (PQRI), Medicare's first pay-for-performance program for physicians has garnered less-than-enthusiastic results. In the first year of the PQRI program, only about 15% of physicians participated in the program. Far fewer received bonuses, and those who did, received only a few hundred dollars each. Given the amount of work involved in this process, it's no surprise that participation was so minimal. Not only is this a burdensome process, but it is also somewhat insulting. After all, airline pilots are not paid based on quality results, nor are their outcomes data publicly posted.

These annoyances are the result of our current “non-system” being completely broken.

Lack of Support for Health Information Technology

Part of this frustration is the lack of health information technology (HIT) that is being used. Way back in the summer of 2004—some 5 years ago—the Department of Health & Human Services released its *Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care*. As we head to the end of this decade, we find that we are nowhere closer.

The stimulus package as it stands today includes \$19 billion in funds to modernize HIT. This is certainly needed given the findings from a study supported by the Office of the National Coordinator for Health Information Technology, published in the *New England Journal of Medicine*, which found optimism for expanded use of electronic health records (EHRs). While there is certainly optimism for HIT, it is used by only 17% of doctors. Another 16% have acquired a system, but haven’t booted it up yet, and 26% say they plan to buy a system within 2 years. Another study noted that only 4% of physicians have a fully functional system that could satisfy some of the basic standards set by the Certification Commission for Healthcare Information Technology. With a price tag of between \$35,000 and \$50,000 per doctor over 3 years, implementation of an EHR can be costly. Even with the high price tag, it is not surprising that the uptake is limited and will continue to be limited unless systems of care are put into operation.

Disproportionate Reimbursement

We can only get where we need to go through an entirely new way of thinking—doing the same old thing and expecting a different outcome is the definition of insanity. But even the organizations that we respect and admire are stuck in the same old patterns. The American Geriatric Society (AGS), for example, is pushing members to join the American Medical Association (AMA) in hopes of holding onto their seat in the AMA’s House of Delegates.

John E. Wennberg of Dartmouth has identified the high percentage of specialists as a major problem within our current health care system. He describes supply-sensitive care, referring to services for which the supply of a specific resource (eg, the number of specialists per capita) has a major influence on utiliza-

tion rates. Physician visits, hospitalizations, stays in intensive care units, and imaging services are all examples of care for which the local supply influences the frequency of use. Variations in supply-sensitive care are largely due to differences in local capacity and a payment system that ensures that current capacity remains fully deployed.¹

The AGS is seeking a seat at a table we have no business dining at. The time has come for the AGS and its members to step away and forge a new path so we can fulfill our vision of ensuring that every older American receives high quality, patient-centered care. Membership in the AMA works against this goal. Furthermore, by participating in the present system, the AGS only lends credence to the Centers for Medicare & Medicaid Services’ (CMS’s) view that the AMA’s Resource-Based Value Scale Update Committee (RUC) represents all physicians. Rather than joining the AMA, the AGS should withdraw from all participation with it, and our members should cancel their AMA membership if they already hold such. Our members should engage in the process of reimbursement reform, stay informed, and be vocal. The AGS should take the lead in pursuing a new system led by an independent group such as the Medicare Payment Advisory Commission (MedPAC) or similar independent body that, like the AGS, works to ensure that every older American receives high-quality, patient-centered care. The time is right for a break from sticking with the same old process, hoping for a better outcome.

Gross Inefficiencies and Senseless Rules in Medicare

Let’s start with the gross inefficiencies that come from a fragmented nonsystem. Take, for example, the fact that this approach has resulted in no support for transitions of care. In addition to control utilization, Medicare requires hospital stays of 3 days before skilled services can be rendered. This is all the result of fragmentation—fragmentation that results in a waste of time and resources because an efficient system has not been put into place.

Restrictions on Expanded Use of Team Members

There is no support for a team in our current reimbursement nonsystem—the medical associations seem to be fighting creation of teams. For example, the American Medical Directors Association (AMDA),

with a tag line that says it is the professional association of medical directors, attending physicians, and others practicing in the long-term care continuum, is dedicated to excellence in patient care and provides education, advocacy, information, and professional development to promote the delivery of quality long-term care medicine. However, nurse practitioners, physician assistants, and consultant pharmacists are simply noted as “others.” This isn’t a team approach. Instead these organizations and the entire nonsystem should be focused on expanding the role of all health care providers so that care can be improved for the seniors we are all serving.

Lack of Motivation for Personal Health

Last, my list of grievances could not be complete if I did not include the frustration I and other physicians have with patients who are not motivated to do the right thing regarding their personal health. Instead, daily we deal with patients who are unwilling or unable to make the necessary adjustments in their lifestyles so that their health can be improved, and this failure to take responsibility results in greater use of health care resources.

We are also forced to deal with patients who demand services that are unneeded and unnecessary—services such as magnetic resonance imaging (MRI) of the spine for acute back pain, which more often than not resolves on its own without any treatment. Yet patients demand expensive studies that oftentimes result in typical findings that promote unneeded, dangerous, and expensive surgery.

Solutions

So what’s the solution? Creation and support of a system of care, a system that cares for a community of seniors until the end. A system that has incentives to improve quality of life through an efficient and effective health care team. Examples of these systems include the Veterans Affairs, Kaiser Permanente, the Program of All-inclusive Care for the Elderly (PACE), and Evercare.

Of these, perhaps the best example is PACE. The PACE model began to evolve in the early 1970s in an effort to help Asian-American and other non-English speaking communities of San Francisco care for elders in their own homes. For people of these ethnicities, placing frail, elderly family members in a nursing home was not a culturally acceptable solution. Therefore, On Lok Senior Health Services created an inno-

vative way to offer a comprehensive array of medical supervision, physical and occupational therapies, nutrition, transportation, respite care, socialization, and other needed services.

The benefits for these seniors living outside of the nursing home have been demonstrated in several studies. For instance, a 1996 study of Washington, Oregon, and Colorado seniors who were eligible for nursing home concluded that the expansion of home- and community-based services was a cost-effective alternative to institutional care in these states.² Physicians should consider the cost-effectiveness of home-based services offered in the community for their patients while also developing a referral source to the nursing home for those that truly require that level of care. By expanding the reach of the clinical team, we can afford significantly more depth and breadth of care.

So imagine a world where we all work together to support the development and use of an interdisciplinary care team that works within a comprehensive system to care for seniors in an efficient and effective system. Wow—wouldn’t that be incredible. And it is possible—but only if we all choose to make it so by working together to accomplish what is not only possible but essential. This would be real change!

Instead of fighting over turf, our professional organizations need to come together to support quality geriatric care that is only possible through a team. All too often we talk about the importance of the geriatric team in our isolated professional meetings. This is one reason why it has been so refreshing to be involved in the Advancing Senior Health (ASH) Conference. ASH has been successful in not only promoting the role of the team but doing so through an open dialogue with all the different care teams present in one room. (For more information about ASH, see <http://www.ash-conference.com/html/for-the-media.html>).

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