The Stethoscope

Quarterly newsletter of the Erie County Medical Society

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A Note From Your President-Elect

A Change for the Better?

Jeffrey McGovern, MD, FCCP, FAASM
ECMS President-Elect

Most physicians young and old are well aware of the ever increasing burden of meeting and sustaining guidelines, treating the sicker patient and then trying to document one's work in the patient record. In July 2018 Proposed Rule for the 2019 Medicare Physician payment Schedule, the Centers for Medicare and Medicaid Services (CMS) recommended profound documentation and payment changes for new and established office visits (99201-99215). As part of the "Patients Over Paperwork" initiative, the intent was to allow physicians more time with their patients and less time for documenting, thus reducing the so-called "note bloat." What transpired was an example of cooperation thus far among CMS, American Medical Association (AMA) and the sundry medical societies representing the country's physicians and providers. I will review this historic cooperation in general as the details of the final recommendations are professionally protected and now under review by CMS.

As part of the Proposed Rule in 2018, CMS also proposed to collapse payments for the office visits for both new and established patients. As their proposal was set to take effect in less than one year, the medical community, along with the AMA and Relative Value Scale Update Committee (RUC), objected in unity and suggested that it would be best to devise an alternative coding solution that could be used by both Medicare and all payors. Fortunately, CMS did "recognize that many commenters, including the AMA, the RUC and specialties that participate in important committees, have stated intentions of the AMA and the CPT Editorial Panel to revisit coding for E/M office services in the immediate future." The CMS proposed

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A Change for the Better?

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a two year delay in implementation to give a special workgroup mandated by the chair of the RUC time to devise this alternate coding plan.

The workgroup, made up of members of the RUC and representing various medical and surgical subspecialties, convened over a six-month period and had several conference calls and one open meeting, all of which were open and transparent with close to 300 attending the meetings. CMS staff also attended these meetings. Surveys were also sent out to providers and solicited feedback from national medical societies and other health care organizations prior to these conference calls. These surveys in turn were shared with participants and used to develop a new coding plan.

Input from professional stakeholders led the workgroup to agree with CMS to eliminate the history and physical exam in selecting a code level. This does not mean, nor should it ever mean, that the provider stops documenting the history and physical. It was a recognition that with the proliferation of the electronic health record (EHR), documentation of these parts can be duplicative and burdensome, leading to the charge of note bloat. The workgroup decided that code selection should be based on time spent with the patient by the physician or qualified health care professional (QHP) on the date of patient encounter or medical decision making (MDM). In early 2019 the CPT Editorial Panel approved the workgroup's recommended new CPT guidelines and descriptors. The guidelines were presented at the last RUC meeting in April and approved for submission to CMS. Again, the details cannot be shared at this setting but the RUC did recommend by a majority new guidelines for office visit codes 99202-99205 and 99211-99215 (99201 was deleted). These recommendations are now in the hands of CMS which will either accept or decline them for implementation in January 2021.

One of the most telling features of these historic six months was the recognition of the burden of EHR. According to the CDC, use of EHR increased from 35% in 2007 to 87% in 2015. [1] The EHR contains more data than the paper records and increases physician work by increasing the time the physician or QHP spends documenting the medical record. The discussion and recommendations of the workgroup did indeed recognize this very reality as well as the decrease in efficiency which may never be fully regained. It is a testament to the daily stress felt acutely and daily by the modern physician and QHP.

The cooperation of fellow physicians and QHP working with their respective societies led to the historic recommendations.

The cooperation of fellow physicians and QHP working with their respective societies led to the historic recommendations. The individuals who were an active part of the workgroup volunteered countless hours to generating an alternative plan and delaying the implementation of an abrupt plan by CMS that would surely have severely disrupted the care of patients. Now, the decision is in the hands of CMS. Will this be a change for the better to reduce needless documentation and lead, as is the clarion call from CMS, to more time with patients, or will it be the same coding plan with similar documentation and lack of recognition for the increased work providers do for their patients? The Final Rule for 2021 is yet to be published. Stay tuned.

(1) https://ehrintelligence.com/news/physician-ehr-use-workload-trumping-face-time-with-patients

What Happened to Direct Patient Care?

Thomas Falasca, DO

A recent article in JAMA Internal Medicine (Chaiyachati et al) examined how PGY-1 physicians spent their working hours. It concluded that 66% of the time was spent on indirect patient care, mostly medical records and documentation. Meanwhile, direct patient care consumed 13% and education was 7%. Multitasking consumed 16% of their time.

For balance, the study hypothesizes, regarding direct patient care time, "More may not be necessary given that so much of patient care now occurs in teams, is informed by diagnostic test reports, and is mediated through the work of others."

These findings are deeply disturbing.

First, documentation is not "indirect patient care," it is documentation. As an attempted surrogate measurement of patient care, documentation has profound failings. Further, experience in documentation is not the experience in medical practice which post-graduate education is meant to provide.

In contrast to patient care, documentation is more readily measured and, unfortunately, more readily adjusted. When documentation and medical practice diverge, the incentive is to adjust documentation rather than to amend medical practice, especially when documentation is the parameter more likely to be scrutinized.

Second, of concern is time spent "multitasking." Nobel-winning experimental psychologist David Kahneman elucidated the availability bias, the human tendency to erroneously judge phenomena that come to mind more readily as also being more probable. Kahneman found that the availability bias affects those engaged in simultaneous effortful tasks more than those not so engaged. In short, multitasking comes with a price; multitasked patient care is compromised patient care.

Third, it is poorly reassuring that much patient care occurs in teams mediated through the work of others, since a weakness of teams is that they dilute responsibility. This dilution phenomenon is evidenced by the work of psychologists John Darley and Bibb Latane. Dilution of responsibility is a poor way to teach the proactive assumption of responsibility that post-graduate training is expected to develop.

Fourth, another poor reassurance is that more direct patient care may not be necessary since much patient care is informed by diagnostic test reports. One difficulty is that many physicians lack the statistical background to draw appropriate conclusions from test reports.

Indeed, Ros Bramwell authored an investigation in which she presented 42 midwives and 41 obstetricians with the information that 1% of the babies in a population had Down syndrome and that a test is positive in 90% of Down babies and 1% of healthy babies. She asked them to estimate the probability that a positive screening test meant that a baby from that population had Down syndrome. Only 18 of the 41 obstetricians and none of the 42 midwives answered correctly. The probability is actually 47.6%.

Finally, the test results, along with their inevitable limitations, must be explained to the patient clearly and compassionately. Any patient choices presented by the test results must also be explained to the patient. Indeed, diagnostic testing may increase, not decrease, the need for direct patient care.

In conclusion, the authors of the Chaiyachati study are to be congratulated. This significant study deserves to be replicated, and if confirmed, it deserves to be aggressively acted upon. This work cannot be allowed to "pass under the radar." Patients deserve better. Doctors in training deserve better.

Thomas Falasca, DO, has been a PAMED/ ECMS Member since 1982 and is the author of *Physician's Guide to Better Medical Decision Making: Critical Thinking in Medicine*

Member News

New

Adedeji Ademiluyi, MD
Bryan Geoffrey Anderson, DO
Amy Beckman
Sarah Brassard, DO
Adam Tyler Bryan, MD
Liane Conte
Mitchell Cunningham, DO
John Phillip Dupaix, MD
Nathan Christopher Ellis, MD
Michael John Furey
Xinyi Ge, MD
Rex Gido, DO
Eric Goodrich, DO
Shahida Khatoon
Abhijth Kudaravalli
Zachary Kwasnicka, DO
Kevin Liberty, MD
Weilin Liu, DO
Mark Robert Lohkamp, Jr., DO
Shane Lohss
Bethany Malone, MD
Patrick Mingledorff, DO
Tran Nguyen, MD
Patrick Philip Ottman, DO
Sejal Akash Patel, MD
Brian Pickering, DO
Tyler Jeffrey Pratte
Maximilian Roemer, DO
Nirali Shah
Brandon Shute
Chad Stratford, MD
Tanner Tuggle, DO
Nikole Van Wie
Ashley Elizabeth Wagle

Reinstated

Clarice M. Dixson
Tran Nguyen, MD
Kara Yakish, MD

In Remembrance

Jack Gold, MD
Francis K Mainzer, MD

Upcoming Events

Watch for details about an upcoming ECMS social event in conjunction with Tall Ships Erie 2019!

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Annual Dinner and Business Meeting
Thursday, November 21, 2019

Watch for details!

Join your fellow ECMS Members for our Annual Dinner and Business Meeting and for the Inauguration of Jeffrey McGovern, MD, FCCP, FAASM as ECMS President.

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Sponsorship details can be found here: http://www.cvent.com/d/ybqhx3

PAMED Quarterly Legislative Update

Venue Rule

Background

• On Dec. 22, 2018, the Pa. Supreme Court Civil Procedural Rules Committee (Committee) published a proposed rule change in the Pennsylvania Bulletin, which would revise the venue rule (the county in which a case may be filed) for medical liability cases.

• By allowing venue in counties with little to no relation to the underlying cause of action, claimants could shop for verdict-friendly venues in which to file their suits.

• The Pennsylvania Medical Society (PAMED) mobilized a movement through stakeholder involvement to flood the Committee with comments. PAMED formed a coalition of 42 state-based organizations who oppose the proposed venue rule changes.

• There is strength in numbers - 2,560 physicians, patients, and other stakeholders submitted comments directly to the Committee through PAMED's online form. PAMED thanks all physicians who submitted personal comments.

• PAMED submitted a 101-page report to the Committee.

• Senate Resolution 20 was approved by the Pa. Senate on Feb. 5, 2019. It calls for a study to review several aspects and impact of previous medical liability reforms, which will enable a more measured approach to any future changes to rules governing venue in medical liability actions.

Current Status

• The Pa. Supreme Court has agreed to accept the recommendations of Senate Resolution 20 and delay its decision on the proposal in order to await further study by the Pa. Legislative Budget and Finance Committee (LBFC) of potential effects of venue rule changes. The report is due no later than Jan. 1, 2020. The fight isn't over and it's still vital for physicians to voice opposition to venue rule changes.

Next Steps

• All physicians are encouraged to meet with legislators to discuss how the proposed venue rule changes would affect medicine and specifically their practice. Personal stories will help to keep this issue front of mind for legislators while the LBFC drafts its report. Find your local legislators and resources for a legislative visit at www.pamedsoc.org/VenueRule.

• On March 22, 2019, PAMED met with the LBFC. PAMED shared our comments that were submitted to the Court's committee and offered our help with its study. PAMED also plans to testify at an upcoming LBFC hearing.

Prior Authorization Reform

Background

• PAMED is seeking a legislative fix to the prior authorization process to address patient care issues, such as delays in needed treatment. Our efforts are supported by a coalition of more than 50 patient and medical advocacy groups and is recognized as a national issue by the American Medical Association (AMA).

Current Status

• Lobbyists for physician stakeholders met in February 2019 to outline a plan for bill introduction, discuss bill language, and strategize a plan for the 2019-2020 legislative session.

Next Steps

• The stakeholder group is working with State Rep. Steven Mentzer as sponsor of the bill and co-sponsors are being sought.

Team-Based Care and Scope of Practice

Background

• Some things are just better together, and physicians and health care team members are no different. PAMED strongly opposes any legislation that does not keep physicians as the leader of the health care team.

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• Currently, Pa. law requires certified registered nurse practitioners (CRNPs) to have a collaborative agreement with a physician. As organizations representing CRNPs pursue policy changes that would give these practitioners the authority to practice without a collaborative agreement with a physician, PAMED remains committed to opposing this legislation.

Current Status

• In a letter sent to members of the Pa. Senate Consumer Protection and Professional Licensure Committee on March 25, 2019, PAMED expressed strong opposition to SB 25, which passed out of committee on March 27, 2019. Senators Mike Regan and John Gordner opposed this bill.

• In a letter sent to Pa. House members on Feb. 11, 2019, PAMED expressed our strong opposition to Rep. Jesse Topper's proposal (HCO 854) . The Pennsylvania Chapter of the American Academy of Pediatrics, Pennsylvania Chapter of the American College of Physicians, Pennsylvania Academy of Family Physicians, and Pennsylvania Osteopathic Medical Association signed on to our letter and joined PAMED in opposing this effort.

Next Steps

• We encourage physicians to reach out to their legislators to meet with them on this issue and educate them as to why this is a bad idea for patient care in Pennsylvania. Get your legislators' contact information at www.legis.state.pa.us/cfdocs/legis/home/findyourlegislator/#address.

• The PAMED government relations team continues to educate legislators and the public regarding our concerns with this legislation.

• PAMED will host a stakeholders meeting on Thursday, June 13, 2019 in Harrisburg to discuss our collective strategy related to scope of practice issues. Physician leadership of county and specialty medical societies have been invited to attend.

Narrow Networks/Any Willing Provider/ Out-of-Network Balance Billing

Background

• PAMED believes that patient protections from "surprise" and other out-of-network health care billings should begin by addressing the root cause of the problem – tiered and narrow health insurance provider networks as well as a lack of insurance product transparency.

• An informational meeting took place on Feb. 5, 2019, within the Pa. House Insurance Committee. The Pennsylvania College of Emergency Physicians and the Pennsylvania Society of Anesthesiologists submitted testimony.

Current Status

• PAMED continues to participate in monthly Provider Coalition meetings to advance legislation and strengthen communications between stakeholders.

Next Steps

• There have been many changes in insurance coverage and health delivery over the past 20 years. The Provider Coalition strongly encourages the Pa. House Insurance Committee to hold a future hearing on network adequacy requirements and potential updates to the law.

Maintenance of Certification (MOC)

Background

• While physicians are committed to lifelong learning, the current MOC process is burdensome for physicians.

• The American Board of Medical Specialties' (ABMS) Vision for the Future Commission on MOC reform released its final report and recommendations in February 2019. PAMED Past President Charles Cutler, MD, MACP, is

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one of 26 members who participated in the Vision Commission.

• The report offers recommendations that the ABMS and ABMS Boards should consider implementing in the near-term (i.e. one to two years) or within an intermediate timeframe (i.e. less than five years). Of note is the recommendation that ABMS must encourage hospitals, health systems, payers, and other health care organizations not to deny credentialing or privileging to a physician solely on the basis of certification status.

• On March 12, 2019, the ABMS Board announced a plan to begin implementing the Vision Commission's suggestions.

Current Status
• On a webinar hosted by AAMSE on April 1, 2019, Dr. Richard Hawkins of ABMS shared that all 24 ABMS Boards have committed to identifying alternatives to the high stakes exams and having alternatives identified by the end of 2019 so that the alternative options are in place by 2020.

Next Steps
• PAMED continues to explore possible legislative solutions to ensure that the MOC process is fair for all physicians.

Stay up to date at www.pamedsoc.org/MOC.

Physician Wellness

Background
• PAMED believes in improving the practice environment for physicians in Pennsylvania. State legislators can help by recognizing the factors that often lead to "physician burnout" and work to resolve them, or at the very least, lessen their impact.

Current Status
• On March 12, 2019, PAMED President Danae Powers, MD, provided written and oral testimony with state Representatives at a Pa. House Health Committee hearing on barriers to employment in the health care field. In her testimony, Dr. Powers encouraged policymakers to learn what happens behind the scenes in physician offices, hospitals, and operating rooms, working with physicians to better understand some of the barriers that make practicing medicine difficult.

Next Steps
• PAMED will continue to ask legislators to support proposals that seek to return clinical autonomy to physicians so that they can do what is right for patients.

The Foundation of the Pennsylvania Medical Society held its Physician Resiliency Summit on June 5, 2019. Learn more at www.foundationpamedsoc.org/summit.

A Look Ahead

• ASC Tax: We can expect that the budget will take up a great deal of legislative time during the session between now and June 30. Gov. Tom Wolf's 2019-2020 state budget proposes a provider tax on ambulatory surgery centers (ASCs) and endoscopy centers to generate $12.5 million on an annual basis. PAMED supports specialty societies in opposing this tax by urging members to contact lawmakers to oppose, stating that this tax will drive up health care costs and put surgery centers at risk of closing.

• PAMED's Bill Tracker: Our new Bill Tracker/ Legislative Update page allows members to stay up to date. You can access it at www.pamedsoc.org/BillTracker. You can also stay up to date via PAMED's Bills on the Hill Blog at www.pamedsoc.org/BillsontheHill.

Stay up to date on PAMED's legislative priorities at www.pamedsoc.org/Advocacy.

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2018 – 2019
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