The Changing Context of Patient Care: Physician Practice in a Redesigned System

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Health Care Spending as a Percentage of GDP, 1980–2013

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

* 2012 Source: OECD Health Data 2015.
### EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>Country</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tbody>
<tr>
<td>Overall Ranking (2013)</td>
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<td>11</td>
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<tr>
<td>Health Expenditures/Capita, 2011**</td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
<td>$4,495</td>
<td>$5,099</td>
<td>$3,182</td>
<td>$5,669</td>
<td>$3,925</td>
<td>$5,643</td>
<td>$3,405</td>
<td>$8,508</td>
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</tbody>
</table>

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
How did we get here?

Volume was/is king.

17 year lag.
What have some of the “solutions” been?
What have some of the “solutions” been?

• **Balanced Budget Act of 1997**: expense per medicare beneficiary cannot exceed the growth in GDP---otherwise known as the “Sustainable Growth Rate”

• **Medicare Access and CHIP Reauthorization Act of 2015**: removes the SGR and creates two different value driven paths for physician payment
Physician Quality Payment Program

Starting in 2019....

VM  PQRS  MU

MIPS  APM
Payment Under MACRA

APM: Bonus of 5% of PFS payments annually

APM: 0.75% annually; no bonus payments

MIPS: 0.25% annually, PLUS penalties/bonus up to ± 9%

0.0% annual update
The results so far....
QUALITY
THE RACE FOR QUALITY HAS NO FINISH LINE—SO TECHNICALLY IT'S MORE LIKE A DEATH MARCH.
• The result is Burnout
• Different skills are needed to survive and thrive
Teamwork is Key
Need new competencies focused on Value

• Comparative effectiveness: not all that makes dollars makes sense
• Lean/Six Sigma training: reliable and waste free, better for all
• Documentation and coding expertise: not just about billing
• Training in large policy changes: all now have clinical implications
• Systems based training in shared decision making
The cure for what ails us.
How can we address this in MOC?

- MOC must address the new skills needs
- MOC must continue to address/assess the clinical competence
- MOC must become part of daily life: not simply an expensive, marginally relevant, periodic love/hate relationship with our respective colleges
How can we address this in MOC?

- American Board of Anesthesiology
- MOCA minutes
  - 30 questions per quarter
  - 60 seconds allotted per question
  - Email prompts or a phone app when convenient
  - Cannot access more than 30 questions a day
  - Promotes the most learning at 3 to 5 per week

- The content of this approach can be adapted to all the new skills needed
• If we don’t make MOC relevant, we become irrelevant.
All of us are needed to get this right