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Gastroenterology Practice 2015

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"The best way to predict the future is to invent it." (Alan Kay)

July 30, 2009: Washington is in turmoil over health reform. Access, quality and cost are accepted goals, but the price tag of change has paralyzed Congress. Politicians argue about which "wealthy" Americans will pay the $1 trillion in added expenses (you and your offspring definitely will). There is no serious legislative attempt to alter true cost drivers — our disjointed delivery system and fee-for-service reimbursement.

Within this maelstrom, you need to do seven things: 1) ignore Washington, 2) focus on patient value (quality-per-unit cost over time), 3) maximize/standardize your internal processes (governance, clinical practice and analytics), 4) go electronic, 5) develop clinical service lines, 6) understand Health 4.0 and 7) help create an accountable care organization (ACO).

For the record, you do not need to be big to be innovative and prosper. While I practice within a 76 provider (56 MD, 20 mid-level) independent GI group, I am humbled frequently by forward-thinking solo practitioners who have adopted advanced electronic records and provide high-quality (accountable) care. A gastroenterologist from rural South Carolina e-mailed me the following:

"Just like you, I am interested in work-flow analysis [and] cutting redundancy in operations, unless there is value to patients. In my office endoscopy unit, I do eight cases a day [moderate sedation]. I am in the office six to seven hours to see patients and help patient flow. I have trained my PA to ... maintain chart order and intelligently discuss simple problems for which patients may make a [return] visit. I see almost all new patients myself. In a typical day, I see 10 new patients and with my PA, we see about 15 re-checks and follow-ups. We have a busy liver/IBD practice. My patients have my phone number but I rarely get called ... I have avoided expanding the practice because I like to go home by 1:30 p.m. every day and work on my own terms on Friday (two to four hours)."

"Our endoscopy monitoring record is a single-page document that meets the Accreditation Association for Ambulatory Health Care requirements for documentation and captures 40 different data points useful for benchmarking. I am making a Web 2.0 version of the product so that users can have the advantage of comparative data with their peers."1

In addition, patients receive their records electronically (if desired) and he encourages them to establish their own longitudinal personal health record. Pending resolution of security issues, he is ready to implement a patient-accessible peer-to-peer communication network.

Here is a solo practitioner who created an efficient practice, leveraged his assets with a physician assistant, developed focused clinical service lines (liver and IBD), produces price and quality metrics, built the infrastructure needed for a specialty medical home, and is prepared to utilize Health 2.0 for communication and care coordination. I don't think I can define a GI practice of 2015 with any more clarity — I was tempted to ask for a job.

No matter what happens in Washington, infrastructure and payment reform is coming to you. On this issue, there is broad consensus and no need to await or expect legislation. See references about types of value-based reimbursement including, "episodes of care," Prometheus methodology and global payments.2-5 Value-based payment, as currently proposed, requires practices to be a coordinated team that follows evidence-based guidelines, tracks resource use and clinical outcomes, and assumes financial risk. The days of individual colon preps and "I biopsy for Barrett's my way" are gone. Practices will be decimated unless they truly understand how to manage bundled payments (with risk). Step one for most will be the development of

strong practice governance (that can hold partners accountable for outcomes and resource use) and consensus on practice processes.

By 2015, successful groups (from solo to mega groups) will publish practice-level quality metrics routinely and will accept bundled payment first for GI care and then for global care as a member of a regional ACO (with quality incentives included). Electronic records will mature from the crude systems of today to regionally interfaced systems that support risk contracting. Independent physicians will participate in ACOs (usually in the form of an independent practice association [IPA]) if there is a relaxation of current legal restrictions on the formation of IPAs.

Medical societies (including the AGA) will manage national outcome registries that will help practices augment income through performance-based payments. Practices will benchmark health outcomes and efficiency for both cognitive and procedural care while providing price and quality transparency to all stakeholders.

Finally, Health 1.0 will mature to Health 2.0, 3.0 and 4.0 with condition-specific social networking, e-visits, bundled pricing and worldwide access to physicians with subspecialty skills. Forward-thinking practices will develop centers of excellence and will incorporate all needed services within their virtual practice walls (GERD, colon cancer, obesity, IBD, liver, pelvic-floor and rectal conditions to name a few examples). These centers will meet demands for care coordination and marketing will be "viral." The term "viral" refers to "word of mouth" information about practices or disease management disseminated by patients onto social networking health Web sites such as www.patientslikeme.com.

The science of gastroenterology will progress at a slow, steady rate, but our practices will change at lightning speed. Does this seem scary to you? Sure it does. But in being scared, lies the opportunity to evolve to enhanced practice models where quality is rewarded and patients' experience is enhanced.|

References

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