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CONSULTING GROUP, LLC

MEMORANDUM

February 7, 2014

To: Jennifer Reck, Jessa Barnard

From: Scott Good

RE: Payment Reform Survey

The following memo summarizes the responses to the 2014 Payment Reform Survey conducted by Crescendo Consulting Group on behalf of the Maine Medical Association (MMA). Results are reported in the four key areas of inquiry: respondent profiles, payment reform participation and issues (including models in use), perceptions and use of electronic health records, and payment reform learning opportunities.

Methodology

In January 2014, the MMA created and disseminated a survey to its database of practicing and non-practicing members. The survey includes questions on several payment reform topics such as those listed below:

- Opinions about current payment reform trends
- Perceptions and use of electronic health records (EHR)
- Payment reform learning opportunities.

Results are presented and crosstabulated by respondents' demographic, working environment, and other factors, as helpful.

The survey and the hyperlink required to access it were developed using the Survey Monkey software tool and disseminated through two approaches: (1) notifying recipients through the MMA weekly update (an online and email resource), and, (2) sending email invitations to MMA members and including the survey hyperlink. Email invitations were sent to practicing members and then two waves of reminder notices were sent out in order to increase participation. In total, approximately 293 respondents took part in the survey for an approximately 13% response rate.

Respondent profile

The respondents to the survey represent a broad cross-section of MMA members based on age range, practice size, medical specialty, ownership and employment models, and geography

- The payment reform survey had a total 293 respondents – most of whom are physicians (98%), and seven of eight (87%) are MMA members. Nearly 300 (N=293) responded to the full survey.
- The respondent pool includes a fairly even spread of age ranges, as 24% are under age 40, 17% 41 to 50 years, 24% 51 to 60 years, and 36% over 61 years of age.
- The respondents represent diverse practice sizes, physician specialties, practice ownership models, employment models, and geographic locations.
    - All practice sizes – solo practice, 2 to 4 FTE, 5 to 9 FTE, 10 to 19 FTE, and 20 or more FTE – are well represented thus far, as they comprise between 15.3% (solo practitioners) and 25.9% (2 to 4 FTE) of total respondents.
    - A broad range of physician specialties are included in the research, as one in four (24.4%) practice family medicine; one in six (17.2%), internal medicine; more than one in ten (10.3%), surgery; and, the remaining 48% are distributed among several other specialties.
    - The ownership models represented by respondents largely fall into two categories: "Wholly owned by a hospital" (40.5%) and "Wholly owned by physicians" (27.8%). About one of six (15.1%) are direct hospital employees, and the remaining respondents operate within some other ownership model.
    - Regarding the employment model of respondents, more than half (54.3%) are employed by a hospital or health system, one of five (18.6%) are employed within an individual group practice, and more than one of nine (12.4%) are self employed.
    - Although the largest percentage of respondents are based in Cumberland County (33.3%), all 16 Maine counties are represented in the survey results.

Payment Reform Participation and Opinions

Most respondents agree that payment reform can be used to address some key needs in the healthcare industry such as aligning payments with clinical care and addressing wage disparities between specialists and primary care physicians.

However, they indicate concern that payment reform initiatives may not be fully effective and efficient.

- Most respondents (79%) agree the current system should be restructured to align payment with optimal clinical care.
- More than half (52%) say that they are prepared or are preparing for payment reform.
- Many respondents indicate that reform policies are being created without adequate provider involvement (77% agree or somewhat agree).
- Fewer than half (42%) are optimistic about payment reform and more than seven of ten (71%) "disagree" or "somewhat disagree" that physicians will be adequately compensated for the additional responsibilities they will take on as part of payment reform.

- Many providers (71%) also indicate that payment reform creates administrative burdens that distract from patient care.

Payment Reform Statement	% Who Agree or Somewhat Agree	% Neutral	% Who Disagree or Somewhat Disagree
The current fee for service system should be restructured to align payment with optimal clinical care.	79%	9%	12%
Payment reform policies are being made without adequate involvement from direct care providers.	77%	13%	11%
Payment reform creates administrative burdens that distract from patient care.	71%	17%	12%
Payment reform must address wage disparities between specialists and primary care.	69%	15%	16%
Payment reform will be implemented on a large scale (beyond existing pilot programs)	65%	22%	13%
I am preparing (or am prepared for) payment reform.	52%	34%	14%
I am cautiously optimistic about payment reform.	42%	21%	37%
I lack the information, tools, or resources necessary to take part in payment reform.	38%	28%	34%
Payment reform will allow physicians to focus more on patient-centered care.	30%	26%	44%
Performance measures on which payment reform is based are reliable and meaningful.	16%	22%	62%
Physicians will be adequately compensated for the additional responsibilities they will take on as part of payment reform.	9%	21%	71%

Payment Reform Models in Use

Nearly all respondents indicate that they understand most payment reform activities to some degree, but – with one exception (pay for performance) – fewer than half are currently participating in them. Within 24 months, though, participation is expected to approximately double.

- Payment reform activities are generally well understood by respondents.
- Six of ten (60.6%) indicate that they are currently involved in a pay for performance activity. An additional 14.8% anticipate doing so within 24 months.
- Within 24 months, half or more of participants say they will be participating in pay for performance, ACO / shared savings, PCMH, and/or bundled payments.
- There is a correlation between the level of understanding and the degree to which physicians anticipate participating in individual payment reform options.

Payment Reform Model Understanding and Use

	Level of Understanding			Participation	
Payment Reform Activity	**Understand Somewhat or Very Well**	**Do not Understand**		**Currently Participating**	**Not participating but plan to do so within 24 months**
Pay for performance	94.9%	5.1%		60.6%	14.8%
Accountable care organizations / Shared savings	84.8%	15.2%		45.2%	31.8%
Capitation	87.9%	12.1%		11.5%	22.6%
Patient Centered Medical Home / Medicaid Health Home pilot	78.2%	21.8%		35.8%	21.4%
Bundled payments	74.7%	25.3%		23.3%	26.0%
Risk withholds	52.7%	47.3%		17.0%	18.9%
Gainsharing	30.2%	69.8%		6.8%	14.0%

Electronic Health Records (EHR) Use and Perceptions

Nearly seven of eight (84%) of respondents use EHR systems and another 11% intend to begin using them within 24 months. However, some see them as not fully efficient.

- Nearly half (45.8%) disagree that EHR improves their job satisfaction
- More than half of respondents agree that EHR provides data-based benefits well
    - Seven of ten (71.7%) agree that EHR provides data in a timely manner
    - Most (89.3%) say that it increases their ability to remotely access patient information
    - Six of ten (59.8%) indicate that EHR provides actionable data
    - More than half say that EHR improves their ability to share data with providers (73.4%) and with patients (50.6%)
- Fewer than half agree that EHR improves some, select care activities
    - One in three agree that EHR increases care efficiency (33.5%) and improves the quality of patient communications (33.7%)
    - About two of four agree that EHR allows them to manage their patient populations (40.5%) and serve patients well (43.3%)

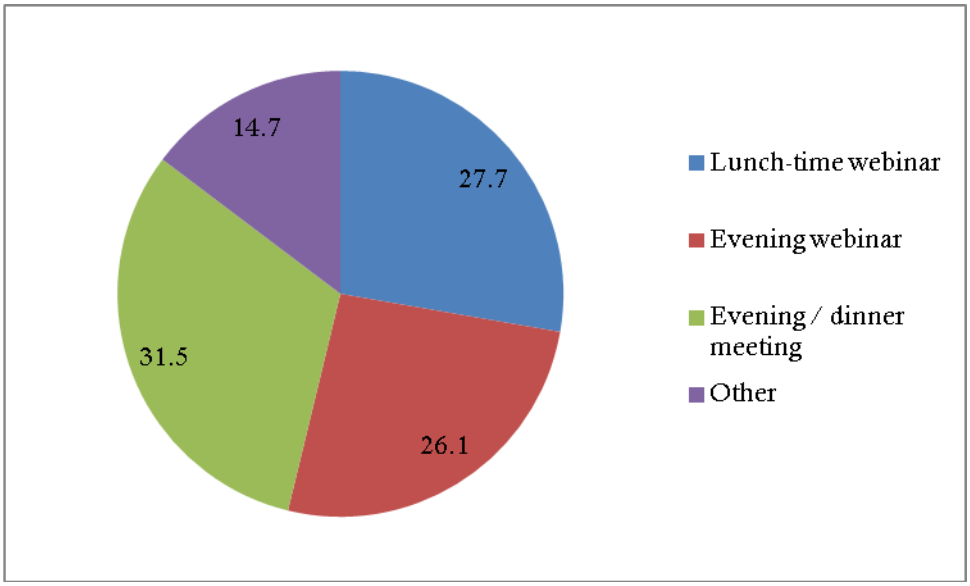
EHR Perceptions

	Agrees or Strongly Agrees	Neutral	Disagrees or Strongly Disagrees
Improves my overall professional/job satisfaction	37.1%	17.1%	45.8%
Improves quality of care	50.6%	16.3%	33.1%
Increases the efficiency of care	33.5%	13.5%	53.0%
Improves quality of communication with patients	33.7%	19.4%	46.8%
Provides an appropriate volume of clinical messages	28.5%	26.1%	45.4%
Provides actionable/useful data	59.8%	17.1%	23.1%
Provides information in a timely/efficient manner	71.7%	15.1%	13.1%
Increases my ability to remotely access patient information	89.3%	5.2%	5.6%
Improves my ability to share data with other providers	73.4%	13.1%	13.5%
Improves my ability to share data with patients	50.6%	25.1%	24.3%
Enables me to manage my patient population	40.5%	32.1%	27.4%
Improves my ability to serve patients well	43.3%	23.0%	33.7%
Allows for time-efficient data entry	22.7%	17.5%	59.8%
My practice has adequate data analytic capacity to interpret and use the data provided	30.0%	24.8%	45.2%

Payment Reform Learning

Survey respondents have a variety of preferences regarding format for payment reform learning sessions.

- Roughly equally numbers of respondents say that they prefer lunchtime webinars, evening webinars, and evening dinner meetings.



There is stronger interest to hear speakers with broader-based knowledge of payment reform issues than to hear functional area experts (e.g., business experts, data specialists, and others).

Interest in the Following Types of Speakers

Speaker Type	Interested or Very Interested
Physician leaders involved in payment reform	75.0%
Local experts on payment reform	69.9%
National experts on payment reform	68.5%
Business management experts	48.0%
Data / EHR experts	45.1%
Legal experts	40.9%
Cost accounting experts	38.0%
Malpractice insurance experts	31.0%
Tax experts	22.6%

- Speaker suggestions vary, but Maine All Care and Dr. Atul Gawande are the most often mentioned. The complete, verbatim table of suggested speakers is shown in the Appendix on the next page.

Appendix A: Verbatim Responses or Recommended Speakers

Verbatim Responses	Count
AAO	
Adrian Gropper, Paul Levy, ePatient Dave, Society for Participatory Medicine	
Al Swallow (2)	2
AMA	
Canadian, Vermont, European experts on system/quality efficiency	
Chris Sprowl MMP	
CMS	2
Consumers for Affordable Health Care	
David Wennberg	
Don Harwood	
Dr. Atul Gawande (4)	4
Dr. Flanigan Chair of State.Innovation Model	
Frank McGinty (2)	2
Friends Committee on National Legislation - health care reform	
Group Health. Someone from the Leap project	
Harold Miller	
Institute for Healthcare Improvement, Don Berwick, Plantree (3)	3
IORA , Medlion, Susan Denzer, NYC doctors and others who are hybrid models-take insurance but take some annual subscription fee too	
Kaiser	
Kaiser, Geisinger, Mayo	
Kraft brothers	
Maine All Care (4)	4
Maine HealthInfoNet	
MaineCare commissioner, senators	
MMA (2)	2
Oprah	
Physicians for a National Health Program	
Physicians for Affordable Health Care (2)	2
PNHP	
Private Insurers	
Professional Societies such as Am. Co. of Surgeons	
Quality Counts	
Rich Peterson	
Richard Bohmer, MD; John Janus, MD	
Someone high up in Maine Health	
'TED' talk like speaker who can explain, tell a real story, use analogies and convey meaning to the avg internist	
US Secretary of HHS or designee (2)	
Vermont Physician leaders in health care reform	
William Rich, MD	

Appendix B: Verbatim Responses:
What resource(s) or tool(s) would help you prepare for payment reform?

Verbatim Responses
A "Payment Reform for Dummies" synopsis
Academy of Neurology
Access to clinical EMR tools for streamlining care.
Automatic coding in the EMR
Better data management for population health (sort by diagnosis, look at catchment area for specific diagnoses)
Better EMR and more help with coding
Better integration with the payer community.
Better speakers - most speakers on the topic are so general that I learn little about how to actually change our practice
Better understanding of how to care for elderly patients while trying to work for quality indicators normally applied for younger adults.
Change in physician compensation and budgeting
Conference, class, internet resource with manuals
Consultants to help increase practice revenue, minimize time spent in non patient care items, those local experts who can convince Maine that ACOs are not answer-State wide other plan
Cost effective software
Education. Eliminating my EMR
Evening webinars
Face to face meetings with members of my department and MMC senior leadership, and large group presentations by speakers noted above followed by small group breakouts if time, resources allow
Financial Modeling and Data Analytics
Get the insurance companies out of it and listen to the government and physicians in systems that truly work
Group training -- both remote and face to face.
Having a better understanding about how payment reform will affect our business model
Highlighted web links and webinars
Information relating Psychiatry to PCMH, Primary Care ICD-10 Conversion Meaningful Use
Informational meetings, webinar, and website for more resources
Internet info site
Internet-based tutorials
Local liaisons within specialty
Local support. Clear and concise information for my patients
Low risk pilot programs
MMA visits
MMC-PHO and its ACO, MMA, AAFP
More education of primary care providers in this area and how to best use data on their pts to direct improved pt care and decreased cost.
More time to read AAFP practice management journal
Much better training on ICD-10 which is going to be a nightmare on top of Payment Reform.
My institution needs to enter the 21st Century and learn about collaboration.
National experts
Online resources
Printed and recorded information to access when I have the chance.
Projection scenarios
Regular updates at all staff or provider meetings

Verbatim Responses
Resources that provide clear description of payment models
Single payer plan
Small group discussion at my office
The tool that would help me prepare for payment reform would be common sense in the people who are designing it. The P4P model will mean payment reduction for physicians who are honest and really do care about their patients. Preparing for P4P now means saving as much money as is possible now because physician incomes will soon be decreasing.
Transition funding
Transparent cost accounting, less 'algorithm" more direct communication about what I am earning/costing the system
Web based presentations
Web chat
Webinar(s)
Webinars

Appendix C: Verbatim Responses:
How are you preparing for payment reform?

Verbatim Responses
Abject panic
Adjustment to lower income and increased practice expense; adjustment to loss of professional satisfaction; acceptance of new interference in rendering appropriate care.
Analyzing our data with Meridiios program
As an employed doctor, I am not but suppose I should
Attending national economic meetings. Participating in local ACO pilot.
Attending physician leadership training.
By changing employment status
Carefully...actually population by population. Increasing PCMH, standardization, Care Management and IT resources
Cautiously; examining options presented to our practice; waiting to see what other practices do within our community
Considering merging with a large multispecialty group
Data entry EMR; paying attention to the news on the subject
Data mining
Deferring to my larger organization
Dropped out of private practice; now work for health system
Educating my staff and patient panel
Educating self as much as possible
Educational work, advocacy for a state system similar to the Vt. efforts already underway
Evidence based medicine
Expect payments to decrease, therefore am investigating alternative revenue options, particularly treatments that will be out of pocket expenses for patients.
Faculty meeting updates
Getting ready to retire
Hospital is taking the lead
Hospital management is working on it
Hospital which employs me is paving way for ACO model, PFP, uses EHR extensively
I am not
I am not.
I am not. I am an employee
I am on the physician reimbursement committee at my hospital and we are linking salary to quality measures, participation in reform, not just RVU
I am retiring from primary care after 34 years but not because of payment reform
I just retired at age 68
I work in a system and many of the decisions have to be directed to the system, not individual perception. For instance, when we participate in bundled payments.
ICD-10 workshops
I'm involved in many of the AAP and MMA activities including IHOC, AAP exec committee, quality counts...

Verbatim Responses
I'm not, really.
Involved in ACO
It will be forced upon me as I am hospital employed.
Looking for career change.
Looking for employed positioned outside of medicine
My hospital system is. I am not.
My organization/employer/health system is doing so
Need help
Newly PCMH, part of ACO
No idea
Not currently applicable to me
Not currently preparing
Not doing so
Not doing so
Not doing so
Not doing so in any way at the moment
Not much; it is all done at another level
Not preparing - leaving it to the medical director
Nothing yet
Our organization is involved with multiple pilot programs for shared savings and risk sharing, as well as PCMH pilots.
Our physician will close his practice and work as a medical director at some facility.
Participating in an ACO, looking into getting a data analytics tool
Participating in Maine All Care,
Peripherally, we are currently participating in established quality reporting initiatives and will likely adopt EHR in the next 1-2 years. Also we are updating our practice management system and plan to attend the upcoming ICD-10 seminar.
Preparing myself to not get paid for 1 to 2 years when the system collapses
Reading about it in NEJM
Reading about it; making changes as needed for ACO
Reading all I can but we are not doing much as a practice.
Reading e-mails that come to me but not much more. As an employed physician I feel sort of disempowered.
Reading throw-away journals and going to meetings with these discussions
Reading what I can
Reading, attending talks
Reading, speaking with the hospital folks, getting outside info
Relying on my employer
Relying on office manager for guidance, updates us regularly so we can adapt ahead of implementation
Remaining part of regional PHO; taking part in local initiatives.
Retiring in June
Specialty ACO quality project working evaluating the guideline for PCSP

Verbatim Responses
Staying attuned to information from departmental and MMC leadership, and to medical literature and national media on the subject
Thinking about retiring
Through MMP leadership
Trying to remain in business as ACOs form monopolies
Trying to understand what is coming down the pike.
Via hospital
Voting against all democrats in future elections!!!
We are currently participating in PCMH and ME ACO
Webinars
Will be working with staff at FQHC that will be billing for my services in the coming months.
Working in the legislature
Working on improving quality and decreasing costs.
Working with our ACO mostly, involved in PCMH Pilot program

Appendix D: Verbatim Responses:
If you are not preparing for payment reform, why not?

Verbatim Responses
Anything associated with Obamacare, I will not participate in
As it is most actions needed for improving reimbursement in my practice conflict with best practices in geriatrics, such as across the board statin use or strict a1c control in frail elderly. I am waiting for CMS to adjust its stand on payment reform to address geriatric issues. I am also concerned that performance based payment will create a conflict of interest for physicians and undermine my patients trust in me. If pay for performance is implemented as is, some patients will start to wonder if I their physicians are making certain recommendations primarily to get bonus pay from CMS or insurance carriers.
As stated, I have just retired. Part of the reason for retiring at this time is/was the coming requirement for EHR. I have seen EHR in operation and have studied it. My PCP uses an EHR in a large network. My observation is that it is slow and highly distracting--he has a great deal less time for direct contact with me and the "helps" that come up to guide him (evidenced) serve only to distract him from honing in on the information I am trying to give him or he should be developing. At this late date and knowing that the EHR is a long way from even adolescence, that there are too many to choose from, many of which are going to disappear leaving practitioners high and dry and a great deal poorer, and in a solo office it will be a time and money hog. The best and easiest way to manage the conundrum was to get out, so I did.
At the end of my career
Awaiting more details to clarify what actually is occurring
Because my institution does everything behind closed doors and clinicians are not able to collaborate
Because payment reform has come and gone many times, each time with no improvement in the system and no significant effect on my practice patterns. Corporate interests are too entrenched and too powerful, and will never allow for meaningful change. My approach to practice has always been to do what's best for patients despite the system's perverse incentives and roadblocks to care. I doubt those will ever change meaningfully in American healthcare. We are a market-based system, and market-based systems will never provide efficient and appropriate care for all patients, no matter how you tweak the details.
Don't understand it well enough.
Have no idea what to "prepare" for as a hospital employed doctor
Hospital employee
Hospital employed. have deferred to the administration for this process
Hospital is leading
Hospital owned with stable salary structure
I am an employee. It is my CEO's responsibility. I take care of patients
I am doing locum work.
I am not seeing patients
I am preparing, but understand that the lies about EHR and the political posturing make collapse before recovery inevitable.
I am relying on my practice administrators and our medical director to take the lead and give me the information that I need.
I am relying on the organization I work for to do the preparations.
I am sure that my employer is preparing; I am just trying to do my work and see my patients
I haven't yet heard of a reasonable plan to research.
I hear no specifics, so I believe it will likely be half baked like all other prior efforts...so why bother?? I just wait to see if they force me to do something, then I learn to do it. I feel very left out of the whole process.
I hope to quit practicing medicine when the IT forms take my staff away from meaningful patient encounters.
Interferes with direct patient relationship.
It is above my pay grade in the organization

Verbatim Responses
It's a mix. I don't think fee for service is going away in the next 5 years. I wish it were.
Leaving it to my employer to work it out
Leaving it to organization
Looking at alternatives to how I'm paid
My impression is that this is still something of a moving target. Waiting to see how this evolves, at least on a local level with our regional healthcare organization.
My only important step has been to use Athenahealth as my EMR vendor. Since they profit from my profits they offer valuable assistance.
My practice is markedly different from what many physicians are experiencing so I hope I don't throw this survey off. I did not answer 18 at all because it did not apply to me
Need has not been presented in our practice
Need help
Need to spend my time caring for my patients and their needs first
No "extra" time on top of usual duties. Haven't realized importance yet with all the other changes going on with my organization.
No idea what I have to do as an employed physician
No info
Not involved in this aspect of the practice
Not sure where to turn to, thinking if important enough, the medical director will set something up
Over the last few years my autonomy to improve the office to prepare for reform has been steadily eroded. Now administrators or IT make changes THEY think improves reimbursement. Helping patients get better and stay better is the only way to reduce costs.
Physicians will be taking responsibility for the actions of patients that they have no control over. If the patients are not compliant and the physician continues to keep them in their patient panel then the physician will take the hit for the patient's actions or in-actions. As I see it, payment reform will ultimately result in less payment to physicians. Physicians will be forced to dismiss certain patients from their practices in order to prevent this reduction in payment. The bar will be raised higher and higher each year and fewer and fewer patients will be able to meet the new standards. Many patients will have insurance and be unable to find a physician that will accept them because they are non-compliant. This is a recipe for disaster but it won't come for a few years. Patients should be responsible for their own actions. Reward them if they lose weight, stop smoking, take their medicine as prescribed, etc. with reductions in the cost of their insurance. Then real change will happen. I have already heard of situations where false blood pressure readings are being recorded so that patients in a certain panel all fall within the proper guidelines. I was saddened but not surprised when I heard about this. I am amazed that no one on the P4P bandwagon considers these outcomes.
Plan to retire
PTSD primary preventive strategies
Retirement looms
The ED environment may not directly be impacted but I suspect there will be shared responsibilities via bundled payments with local health systems.
The whole thing is so unpredictable.
Too busy clinically
Trying to build a new care model, but still making financial decisions and investments based on fee for service
Waiting for hospital directives
Work at various hospitals who have to deal with payment reform, I am not in the direct line of fire

Appendix E: Verbatim Responses:
Additional comments about the survey issues

Verbatim Responses
Again, which direction we go is being determined by the insurers and systems. I feel that even with the reforms occurring now, they will fail unless ALL participants' incentives are aligned. It is very difficult to "wait" for insurance companies to come in board with payment reforms that are meaningful and appropriate. The best solution, even with all its limitations, is single payer.
Biggest problem is third party payers regulating costs and perceived safety but needing to profit. Pay doctors directly for their time like lawyers. The market will regulate their costs and safety just like it does with any business that does not provide consumers with a product they like at a competitive cost.
Current trends in health care reform are extremely worrisome. A bipartisan effort to honestly address real problems seems too much to hope for at present, in Maine and nationally.
Doesn't really address in hospital physician demographics.
Forced use of the EMR is the most important tragic issue I face in practice.
Good survey, not sure when and where I will get more information. I have had some exposure from the State of Maine Insurance regulator who spoke at Bowdoin College and from a CME in Boston.
Great that the MMA is involved in this
Health InfoNet is the only bright spot in reducing costs by improving the flow of information to benefit patients.
How about someone finally getting up as saying that payment reform has nothing to do with medical care of patients?
I am retired from practice and answered based on my recent practice experience with an EMR and moves toward PCMH and ACO's. I am working with the legislature on healthcare payment systems so want to keep current with the active medical practice community experience.
I feel like payment reform is being thrust on us largely against our will and often without much input, especially by small practices/independent physicians. This is a costly endeavor with unclear outcomes. I am skeptical about the expected advances in quality of care and cost savings. All I see right now is a lot of extra work.
I have just retired from a long standing solo practice. The answers to the above questions are based on the history of the practice as of the closing of the doors on June 30, 2014. I am still employed in a clinic roughly three hours a week and see patients in a nursing home (solo, fee for service) one day a week. All of the patients in the home are Medicare or Medicaid I think I am relatively current with the topic of payment reform through current active membership in a specialty committee which has a sole focus on the topic. I may not be the brightest bulb but even with the plethora of information I receive and we discuss, the topic of payment reform remains murky and answers very elusive, the ground shifts continuously, I don't think there are answers and I doubt there are "experts" whose information will be helpful and that we can hang our hats on. I'll be dubious of the long term helpfulness of any current expert. What may be helpful are the experts who can raise our understanding of the background leading to the present activity. With the background the doctors and others who are involved may have a better basis on where all of this is coming from. And, that's my cynical take on all of this!

Verbatim Responses
I have practiced vasc surgery in solo and private practice for 30 years and then joined our hospital as vascular surgeon/director for 7 years prior to retirement. I am disappointed that health care is not evolving to cover all as an intrinsic right. We are the highest paid docs in the world but we don't get the best results and make excuses for our system failures and often tailor treatment to maximize revenue. I have been in financial planning meetings where goal is to order more tests and increase billing rather than improve health, reduce cost, & extend care for those in need. Right now the American public is being gouged by a system of mediocre quality which is way too expensive.
I overhear some but am not familiar with what is going on, or how the practice will change
I personally believe that ACA will not go far to control healthcare costs and will unfortunately leave many in Maine without meaningful or affordable access to healthcare- I think that there is a critical mass of us physicians who believe that some form of single payer is far more likely to be cost-effective and to meet the need in our state. I think it's time for us to physicians to have a conversation with one another and see if we are ready to learn from our experience and put our advocacy to work in a new direction. Ed Pontius MD (MMA and MAPP)
I think more emphasis should fall on health industry other than physicians - currently we seem to be taking the lion's share of the financial burden. I'd also like to see more subspecialty representation at the payment reform level
I think the EHR should improve efficiency and population health management but the hospital implementation does not empower the provider with the needed information. They treat the EHR as an electronic version of the paper record and data collection and "management" is directed at management of revenue and cost rather than patient care. It's the same thing that the auto industry did, rather than improving the quality of their product, they focused on improving the quality of their marketing.
I try not to sleep under a pile of rocks, but why is this the first time I'm hearing about this topic in an organized fashion?
I was disappointed that there was no mention of the importance of clinical coordination with public health in improving the health of Maine people. This could have been included in #16 as part of payment reform issues
I was pleasantly surprised to see the question about single payer. Thank you for including that.
It is somewhat of a moving target. There aren't many listening to the solo practitioner. We solo practices are working together, but it is hard to figure out what we need to do/can do. I am not happy with my EMR. I would like a better one. Cost issues and time issues are important in this, and I don't see a point in just doing it to do it, because I don't believe it's going to make a difference. I see so much junk in the EMR world.
It is very difficult to follow any pay for performance and PCMH funding
Medicare for all but need to analyze effectiveness of interventions. Do they make you live longer (QYL), does the drug actually work or just might work (NNT) and how well. Payment based on effectiveness in a sliding scale fashion. If a Rx works well and patients get more than year extra of life vs. Rx's that "might" or "could" work that are reimbursed at a much less amount based on degree of effectiveness. Fund research by science/EBM not industry or corporate sources.
My job has become a lot harder. Due to the EHR benchmark payments, our hospital has implemented an EHR system that is fragmented and potentially could harm patients. As a physician, I am now a data entry person, coder and soon to be transcriptionist. So much of my job is spent on tasks that don't utilize my skills. So many core measures use outdated data and reward pharmaceutical prescribing above good patient care.

Verbatim Responses
My responses are atypical as I am the sole employed physician in a large hospice and our payment issues are very different. Most important/relevant question for me was the importance of Medicare for all single-payer system. I think this is the only viable, long-term solution
Our EMR is filled with ERRONEOUS data, so it makes all the information suspect and not reliable, thus negating any perceived benefits
Payment for PCMH and primary care use of EMR must be improved so that each provider may have a scribe in their office with them. Only with a scribe will the EMR become a cost-effective tool.
Please fight against implementation of ICD 10.
Please make sure all payers agree on the same quality data, same format. For example NCQA standards rather than multiple demands on practices.
Reform is adding jobs to government, insurance, IT, management, etc but doing little to improve patient care or satisfaction. Docs are too busy at the keyboard checking boxes and quality assurance items that are trivial. The system has turned physicians into transcriptionists while the IT industry rakes in billions of dollars to create new software and upgrades that don't talk to each other. Go back to fee for service and charity hospitals and the marketplace will take care of itself if the government and politicians will keep out of the practice of medicine.
Single payer is the only answer. The sooner the better. Health care is a right and should not be a business. Get rid of insurance companies.
Single payer is necessary but not sufficient. This survey, like most discussions, focuses primarily on payment reform but often seems to think that it is the same as health care reform. Wrong. The two are linked, but fixing the payment system will not create patient-centered care or shared-decision making, prevent errors, or improve outcomes unless these are addressed specifically in their own right - which would be easier and allow more leverage in a single-payer system.
Thank you
Thank you for the survey and your efforts on behalf of MMA members.
The current system is a mess at many levels. Its incentives are all wrong and its outcomes are poor; press on!
The Quality Measures individual physicians are being judged upon are mostly system measures, only partially within the control of those providers. We need a unified payment system or set of rules governing payment. Insurance companies are not going to be the source of good outcomes except by happy accident.
There is no effort to include physicians in information on reimbursement rates proposed for new payment reforms.
Very interested in results of this survey, despite being retired and not personally involved in payment reform in my own practice limited to occasional consultation to the State Forensic Service
We can't really talk about or plan for payment reform until we know what reforms are envisioned. Although I would prefer a single payer system, there realistically is none in sight as long as we are bowing to the insurance companies' lobbies. We certainly are not educating the public that with a single payer system the total health care costs of the country would be lessened.
We need a single payer system as a public health care program to provide a basic level of service and a separate private payer system for those who desire and can afford it.