Op-Ed

Speaking With Doctors in Restaurants

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AS THE SECRETARY OF MARYLAND'S DEPARTMENT OF HEALTH and Mental Hygiene, I've adopted this rule: I accept every invitation to talk to physicians in my state about the changes under way in the health care system. Usually these events happen at dinnertime, during a meeting of a local specialty society.

As a result, in restaurants, hotel dining rooms, locally sourced eateries, and convention halls, I have met with family physicians, internists, pediatricians, urologists, anesthesiologists, emergency room physicians, ophthalmologists, otolaryngologists, surgeons, and others. After a few announcements and updates, the food is served, and I'm on.

I start by saying that if being the secretary of health means that I am the doctor to Maryland's population, then I must report that the patient should be doing a lot better. Despite Maryland having one of the highest median incomes and best educational systems in the nation, its health care outcomes, while improving, are still in the middle of the pack. As is happening across the nation, our health care costs are growing, squeezing out other priorities across the state. And by some measures, our quality is far from optimal. For example, Maryland has recently seen some of the highest hospital readmissions rates in the country.

Now that I have my audience's attention, I tell this story: Two years ago, I was invited to meet with leaders of the Central Maryland Ecumenical Council. Running about 15 minutes late, I arrived to find about a dozen men, each wearing formal clerical attire, seated around a rectangular table. They were staring at me with a look I imagined was usually reserved for a parishioner showing up late for services. After brief introductions, they began questioning me about the Affordable Care Act. After more than an hour, one of the faith leaders paused and asked why health care cost so much.

I responded that because the health care system generally reimburses for each hospital admission and every high-tech treatment, it can't be a surprise that there are lots of hospital admissions and high-tech treatments, regardless of whether they are needed or could be prevented.

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I looked for expressions of understanding, but I only got back blank stares.

Eager to connect with the group, I ventured, "It would be as if each of you were paid by the prayer."

Silence.

No one laughed. No one even smiled. My career flashed before my eyes. After a long time, one minister reached across the table, put his hand on mine, bowed his head slightly, and said, "Let us pray."

What the clergy understood, I say to my audience, is that fee-for-service medicine is not aligned with cost-effective care or, for that matter, with improved health. I explain that there are reforms under way in Maryland and across the country to pay based on the value instead of the volume of health services. Maryland is pursuing an innovative approach to hospital financing and a coordinated model of public health and primary care.¹

It is never long before I am interrupted.

If I am speaking to a specialty society, the initial questions have an edge. I hear about Medicare rate cuts, loss of income, and the potential flight of physicians to other states or other countries. At one of the state's fanciest dining establishments, a subspecialist asked me, "Other than us, Dr. Sharfstein, who is being @#\$!! by these changes?" One surgeon told me that all the doctors in her county were retiring from clinical practice. After I told her that I heard that the new Kaiser outpatient center nearby had 10 physician applicants for every vacancy, she responded: "That's what I'm talking about. All the doctors are retiring from clinical practice. They are joining Kaiser." (I'm never far from being reminded of the unique vantage point of the solo practitioner.)

Eventually, the discussion turns to new opportunities for physicians with the changing times. I ask specialists to consider how they might bundle services and be more accountable for outcomes and costs. We talk about using our health information exchange to improve clinical quality. I encourage them to connect with their national organizations and to let me know if I can be helpful in bridging the gap with insurers. I leave pleasantly surprised that even those physicians who are doing very well in fee-for-service medicine can participate in discussions of payment reform. But this hope is balanced by the reality that change will be difficult.

Primary care doctors interrupt my explanation of Maryland's plans to tell me about how difficult their lives are. "I hear all this talk

about supporting primary care and paying for value,” a typical question goes, “but why does this always seem to lead to more oversight but hardly any more money or time?” I hear appreciation for the intent and general direction of patient-centered medical home programs, but also bewilderment at the requirements, incentives, and quality measures.

I ask primary care doctors about their interest in taking financial risks and leading multidisciplinary teams caring for large panels of patients. Some seem eager for the challenge, but most would like just to have more time to take care of their patients well. Few have any sense of how to maneuver themselves into such a role. They are balancing competing demands from hospital systems, insurers, and patients.

At one presentation to pediatricians, I gave an example of adolescents with moderate to severe asthma and many hospital admissions. “If I were to pay you a lump sum based on the expected number of admissions,” I explained, “then you could use that money up front to build a team that could keep those kids healthier.”

“I refuse to be penalized when my patients come to the emergency department,” responded one community doctor. “I can’t keep some teenagers with severe asthma out of the hospital. They don’t listen to their parents. They don’t listen to me. There’s nothing more I can do.”

I explained that doctors at risk would not be penalized for each admission. Rather, they would stand to gain from reductions against an expected trend, which would take into account the multiple admissions in the past. The doctor still protested. Then I heard myself saying: “Perhaps there are other pediatricians here who are not as hopeless as you and who think they might be able to creatively engage with adolescents with asthma and succeed. If so, maybe you should send your patients to them?”

I rarely get a chance to eat at these dinners. I start talking at the beginning, and when I am done, it’s time for everyone to leave.

When driving home, I reflect on the diversity of understanding, training, and experience in every physician group. I recognize that as challenging as my job can be at times, there is nothing more stressful or important than being responsible for the medical care of others. I wonder when the reforms I am pursuing by day will empower those physicians whom I would trust to manage my family’s health care. I’ll measure the distance not in weeks or months but in dinners.

Reference

1. Rajkumar R, Patel A, Murphy K, et al. Maryland's all-payer approach to delivery-system reform. *N Engl J Med*. 2014;370:493-495.

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